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DEVELOPMENTS IN AGING: 1982
VOLUME 2—APPENDIX

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 333, MARCH 4, 1982
Resolution Authorizing a Study of the Problems
of the Aged and Aging

FEBRUARY 28 (legislative day, FEBRUARY 23), 1983.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., February 28, 1983.

Hon. GEORGE BUSH,
President, U.S. Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 333, agreed to March 4, 1982, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1982, volume 2.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1982 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

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DEVELOPMENTS IN AGING: 1982
VOLUME 2—APPENDIX

February 28 (legislative day, February 23), 1983.—Ordered to be printed

Mr. HEINZ, from the Special Committee on Aging,
submitted the following

REPORT
APPENDIX

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

JANUARY 11, 1983.

DEAR MR. CHAIRMAN: Thank you for your letter of November 10, 1982, requesting an update of the Department of Agriculture's programs and services for older Americans in fiscal year 1982, for inclusion in the "Developments in Aging" report.

Enclosed are reports obtained from the following Department of Agriculture agencies: (1) Office of Rural Development Policy, (2) Forest Service, (3) Farmers Home Administration, (4) Economic Research Service, (5) Rural Electrification Administration, (6) Food and Nutrition Service, (7) Office of Minority Affairs, and (8) Science and Education Administration.

We hope the reports will be helpful to the committee and to individuals and groups in the field of aging. Thank you for giving us the opportunity to submit to the Special Committee on Aging, the annual reports from the Department of Agriculture agencies.

Sincerely,

JAMES H. JOHNSON,
Acting Under Secretary
for Small Community and Rural Development.

Enclosures.

OFFICE OF RURAL DEVELOPMENT POLICY

The rural development policy function was removed from the Farmers Home Administration and placed under a separate office—Office of Rural Development Policy—which reports directly to the Under Secretary for Small Community and Rural Development. The Secretary has delegated to the Under Secretary, responsibility for matters relating to rural development.

The Office of Rural Development Policy, created by the Secretary of Agriculture, has the responsibilities to carry out the Rural Development Act of 1972, as amended by the Rural Development Policy of 1980. In addition, the policy office has the responsibility for working cooperatively with all USDA agencies, other appropriate Federal agencies, and State and local governments in addressing rural development policy issues. The policy office leads the executive branch effort in coordinating the formulation of the rural development strategy called for in the Rural Development Policy Act of 1980.

The Office of Rural Development Policy has a mandate from the Rural Development Policy Act of 1980 to plan and conduct activities that will impact on the rural elderly population.

The following description reflects some of the activities during fiscal year 1982:

Staff member of the Office of Rural Development Policy served as the Department of Agriculture's designate on the interagency Committee on Aging for the World Assembly on Aging at the State Department. The committee was organized to insure the contributions and participation of all segments of the Federal Government having the responsibilites in the field of aging.

A position paper on rural development was prepared for the U.S. delegation for the U.N. World Assembly on Aging in Vienna, Austria, July 26 to August 6, 1982. It is worth noting that the final report of the U.S. delegation has included a principle that addresses rural areas. The principle is "Governments, nongovernmental organizations, and all concerned have a special responsibility to the most vulnerable among the elderly, particularly the poor of whom many are women and *from the rural areas.*"

Worked extensively with the White House Conference on Aging and Green Thumb, Inc., staff. Provided a facilitator at the aging/rural miniconferences in South Dakota, Oklahoma, and California. A "fact sheet" was developed and distributed to the White House Conference on Aging delegates.

A session was planned and implemented at the National Association of Area Agencies on Aging/National Association of State Units on Aging Training Conference in Denver, Colo., in order to gather ideas, comments, and recommendations regarding rural elderly issues for the National Rural Development Strategy. The title of the session was, "Rural Development Strategy: Your Input Will Make a Difference." The session was taped and written up for the Strategy Information Management System entry. The participants addressed many issues including rural transportation, status of section 18; Urban Mass Transportation Act, cash-flow problems, urban bias, inadequate "seed money," community base long-term care development, and the definition of "rural."

600 area development assistance planning grants have been reviewed to identify any innovative or transferable programs which many relate directly or indirectly to the rural elderly needs.

The interagency agreement entered into by the Farmers Home Administration and the Administration on Aging was initiated by the Policy Coordination staff of the Office of Rural Development Policy in January 1979. The two agencies joined forces to enhance the quality of housing provided for the rural elderly. (See FmHA report.) The Office of Rural Development Policy staff monitored the demonstration project and the evaluation by contractor, the International Center for Social Gerontology through December 1981.

FOREST SERVICE

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Agriculture, Forest Service, in cooperation with the Department of Labor, sponsors the senior community service employment program (SCSEP), which is authorized by title V of the Older Americans Act. The SCSEP has three fundamental purposes: (1) Community services to the general public, (2) part-time employment and supplemental income, and (3) training and transition of participants to the private sector labor market. The program employs economically disadvantaged persons aged 55 and older in 38 States and Puerto Rico. The SCSEP seeks to improve the welfare of underprivileged, low income, elderly, and to foster a renewed sense of self-worth and community involvement among the rural elderly.

Program participants are involved in projects on national forest lands such as construction, rehabilitation, maintenance, and natural resource improvement work. Enrollees receive at least the minimum wage to supplement their personal incomes. A major benefit of the SCSEP program is the opportunity participants have to regain a sense of involvement with the mainstream of life through meaningful work. Additionally, valuable conservation projects are completed on national forest lands.

The Forest Service's interagency agreement for July 1, 1981 to June 30, 1982, provided $16.2 million which employed 4,288 persons (19 percent minorities and 31 percent women). The Government reaped a return of $1.41 for each dollar invested in the program. During the July 1, 1982 through June 30, 1983, program, it is anticipated that 4,600 seniors will be employed with funding of $16.8 million.

Farmers Home Administration (FmHA)

(1) *Section 502 housing loans* are available to low- and moderate-income households who will reside in rural areas and currently do not own adequate, safe, and sanitary housing. The interest rate on section 502 loans is currently 11.5 percent, with a maximum repayment period of 33 years. Low-income recipients may qualify for a subsidy on the loan which could lower the interest rate to as low as 1 percent. There were approximately 559 initial loans made to the elderly during fiscal year 1982 and $17,155,780 obligated.

(2) *Section 504 rural housing loans* are available to very low-income households who own housing in rural areas and have minimal repayment ability. These loans are used to remove health and safety hazards. This includes such items as roof repairs, storm windows and doors, insulation, water systems and waste disposal systems. Terms are at 1 percent and up to 20 years. There were 970 initial loans made to the elderly during fiscal year 1982 and $4,850,000 obligated.

(3) *Section 504 grants* are available to very low-income homeowners (62 years of age or older) who lack the ability to repay a 504 loan. During fiscal year 1982, there were 4,205 grants and $13,605,300 obligated.

(4) *The section 515 rural rental housing program* provides rental or cooperative housing for persons with low- and moderate-incomes and for those age 62 and older in rural areas. The loans are repayable in not more than 50 years. During fiscal year 1982, 1,428 loans were made and $953,667,720 was obligated. Approximately 24 percent of these loans were made for the construction of elderly projects.

(5) *Section 515 congregate housing for the elderly and handicapped.*—The FmHA has authority under the section 515 rural rental housing program to build congregate housing for the elderly and handicapped. Congregate housing is an alternative for the elderly who need an assisted residential living environment. It offers the functionally impaired or socially deprived, but in good health (not actually physically ill), the residential accommodations with supporting services to assist them in maintaining, or returning to independent or semi-independent lifestyles to prevent premature or unnecessary institutionalization as they grow older.

The following supportive services are provided in the congregate housing: Meals (at least one a day, 5 days a week), personal care and housekeeping services, transportation, social and recreational activities. Developers who apply to FmHA for loans to build congregate facilities must demonstrate their ability to provide these minimum services. In most instances, developers are coordinating with social service agencies to obtain support in the provision of services.

The FmHA and the Administration on Aging (AoA) entered into a joint working agreement through a memorandum of understanding to provide congregate housing for the elderly. A joint demonstration was initiated in January 1979 as a component of the White House Rural Development Initiatives. FmHA and AoA set aside funds to support demonstration projects in 10 rural areas. Projects have been funded in California, Iowa, Michigan, Mississippi, New Hampshire, New York, New Mexico, Oregon, South Dakota, and Virginia.

Sites were chosen based on the percentage of persons 62 years of age and older, income factors, and poor housing conditions.

FmHA agreed to provide loans in the amount of approximately $10 million and AoA agreed to provide annually $85,000 in grants to support the cost of services provided in each facility. Nine of the projects are completed and fully occupied and have AoA supported services in place at this time.

An evaluation of the demonstration program is being conducted under FmHA contract with the International Center for Social Gerontology (ICSG). In order to get a comparison of demonstration projects to other ongoing FmHA funded 515 congregate housing projects, two nondemonstration sites at Lafayette, Tenn., and New Madrid, Mo., will also be evaluated. The evaluation will be completed in January 1983.

COMMUNITY AND BUSINESS PROGRAMS

Business and Industry Division

The business and industry (B&I) program under the Consolidated Farm and Rural Development Act, sec. 310B (7 U.S.C. 1932) Rural Industrialization Assistance, guarantees, loans for business and industrial development in rural areas. Funds may be used to finance business and industrial construction, conversion, and modernization.

The B&I program does not have target goals for assistance to the elderly in rural areas but has guaranteed loans for projects which benefit the elderly directly and indirectly.

During fiscal year 1982, B&I guaranteed loans for the following projects in rural areas: Hilltop Nursing Home, Kentucky—$975,000; Medical Investment Association, North Carolina—$1,201,500; Wellsville Manor Nursing Home, New York—$2,750,000; and the Buckhannon Eye Association, West Virginia—$975,000.

Since the inception of the program in 1974, B&I has guaranteed loans for over 200 projects benefiting the rural elderly in the amount of $193,283,258.

Such projects include physicians' and dentists' offices, chiropratic and osteopathic offices, skilled nursing care facilities, general medical and surgical hospitals, psychiatric hospitals, medical laboratories, outpatient facilities, and health and allied services enterprises. One hundred and forty-four skilled nursing care facilities have been guaranteed for a total of $145,770,388.

Water and Waste

Farmers Home Administration (FmHA) is authorized to provide loan and grant assistance to develop water and waste disposal systems that primarily serve rural residents in rural areas and in towns up to 10,000 people. Funds are available to public entities such as municipalities, counties, special purpose districts, and nonprofit organizations. Grant assistance may be made available for facilities serving the most financially needy communities to reduce user costs for eligible grant recipients to a reasonable level. In fiscal year 1982, 928 loans were made totaling $375 million and 444 grants were made totaling over $133 million.

Water and waste disposal loans and grants are made available directly to eligible applicants along with financial management assistance from FmHA personnel. This program is not specifically aimed toward helping only the elderly. However, through the program, needed water and waste disposal service is made available to all users in a service area including the elderly.

Community Facilities Loans

Brief Description

Community facility loans are made to public entities and nonprofit corporations that primarily serve rural residents in towns or cities not to exceed 20,000 people.

These loans are made to construct, enlarge, or improve clinics, nursing homes, hospitals, community buildings, fire stations, and equipment or other community facilities that provide essential service to rural residents, and to pay necessary costs connected with such facilities.

Nursing Homes

In fiscal year 1982, 10 loans were obligated for nursing homes in the amount of $6,575,000. Nursing homes directly impact on the elderly in that they are almost wholly occupied by the elderly.

Hospitals

Forty loans were made in fiscal year 1982 for hospitals in the amount of $43,647,550.

Health Clinics

There were nine physician clinics and one dental clinic funded during fiscal year 1982 in the amount of $2,330,500. These clinics provide needed medical services to the rural population.

Miscellaneous Projects

Miscellaneous projects included those facilities such as medical rehabilitation centers, nutritional centers, and vocational rehabilitation centers. During fiscal year 1982, three such loans were made for $1,120,000.

ECONOMIC RESEARCH SERVICE

1982 PROGRAMS AND ACTIVITIES ON AGING

The Economic Development Division began planning work on a retirement growth study in 10 counties of the Missouri-Arkansas Ozarks region. The purpose of the study is to assess the impacts on a rural and small town area of population growth from substantial inmovement of retirees, with implications for business, employment, income, and other aspects of community conditions. Approximately $15,000 in startup costs were expended on the study in fiscal year 1982.

Research was continued from fiscal year 1981 on housing of the rural elderly. The work completed in fiscal year 1982 included a staff report on the subject. The approximate fiscal year 1982 expenditure on the project was $20,000.

A statement on the demographic situation and trends of older rural Americans was prepared for the Senate Special Committee on Aging. The expenditure on this activity was nominal.

As an ongoing ERS activity, one employee has responsibility to respond to requests for information on rural and nonmetropolitan elderly. Requests come from individuals, government agencies, organizations, and the media. Approximately $3,500 in a salary was spent on informational activity in fiscal year 1982.

RURAL ELECTRIFICATION ADMINISTRATION

Although the Rural Electrification Administration (REA) does not conduct direct programs for the elderly population, its program reaches many elderly who are member-owner-subscribers of REA borrowers. Furthermore, REA borrowers not only bring electric and telephone service to the elderly, but also provide a base for many local community activities which reach the elderly. These community activities of REA borrowers are documented in REA's Community Development Survey which has been conducted almost yearly since 1961.

In 1981, for example, REA borrowers voluntarily helped 620 local community groups with 1,585 community service-type projects. REA borrowers' assistance included providing information necessary for project planning, arranging for financing, securing or providing development assistance, and providing meeting space and technical expertise. Many senior citizen groups, congregate feeding programs, and other aging programs in local communities depend on an REA borrower for help in their particular organizations. Many times REA borrower contributions often extend far beyond providing basic utility services.

FOOD AND NUTRITION SERVICE

The Food and Nutrition Service (FNS) serves the elderly in two major ways. The food stamp program and commodities in lieu of food stamps for needy families serve the general low-income population and in this way provide substantial benefits to the elderly. The elderly feeding program and the new pilot projects for commodity distribution to the elderly provide more targeted services. These programs are described in more detail below. None focus specifically on rural areas, but rural areas are eligible for coverage in all cases.

(1) *The Federal food stamp program.*—In 1982, this program was operated in all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. The program provided total benefits of $10.4 billion in fiscal year 1982. The most recent statistics on the participation of the elderly in the program in the 50 States and the District of Columbia are included in a "Preliminary Report of the Characteristics of Food Stamp Households: August 1981." Legislation since August 1981 may have had the effect of slightly increasing the proportion of elderly participants in the food stamp program in 1982. However, on the basis of the 1981 figures, it is estimated that about 9 percent of all food stamp participants in 1982, or 2 million persons, were age 60 or over. (Age 60 is the current demarcation line in the program's definition of "elderly.") Twenty-one percent of all households receiving food stamp benefits, or 1.6 million households, had at least one member age 60 or over. Fifteen percent of all food stamp households (1.1 million) were composed of single elderly persons. In terms of expenditures, it is estimated that households including at least one person age 60 or over received 9.4 percent, or $978 million, of the actual program benefits made available in 1982.

(2) *Commodities in lieu of food stamps for needy families.*—This program donates commodities such as dairy products, vegetables and juice, flour, rice, and shortening to eligible needy persons residing on Indian reservations and in the Trust Territories of the Pacific. Total program benefits in 1982, excluding administrative costs,

were about $28 million. No data are routinely collected on the proportion of participants who are elderly.

(3) *Pilot projects for commodity distribution to the elderly.*—Legislation enacted in 1981 authorized the institution of two pilot commodity distribution projects directed at low-income elderly persons. Benefits would be supplemental to their food stamp participation. The two operating sites, located in Detroit and Polk County, Iowa, began in September 1982, with initial Federal funding of $455,000. Serving an estimated 1,600 participants each, the projects provide for a selection of commodities including dry milk, cheese, egg mix, cereals, juices, canned fruits and vegetables, dried beans and peas, peanut butter, and canned meats or poultry. Under proposed legislation, a third site will be initiated in New Orleans in 1983, with an estimated participation of 1,800 elderly persons. Total 1983 funding for all three sites, as provided for in the conference bill for 1983 appropriations, would be $900,000.

(4) *The elderly feeding program.*—This program provides commodities or cash in lieu of commodities for nutrition programs for the elderly that are operated by local agencies under title III of the Older Americans Act, and by Indian tribal agencies under title VI of that act. The programs provide balanced meals for elderly persons in a congregate setting such as senior citizen centers. In fiscal year 1982, an estimated 180 million meals were served that were supported by FNS cash contributions of 51.5 cents per meal or by commodities of the same value. Total FNS program obligations in fiscal year 1982 amounted to $82.4 million in cash and $10.2 million in commodities.

OFFICE OF MINORITY AFFAIRS

Office of Minority Affairs (OMA) provides leadership and direction to assure equal opportunity in USDA programs and activities. As part of this function, OMA monitors the civil rights compliance status of the various USDA agencies which administer federally assisted and direct assistance programs and activities. Specifically, OMA monitors agency compliance with the requirements of title VI of the Civil Rights Act of 1964 and other Fedeal nondiscrimination laws which prohibit discrimination on the basis of race, color, religion, handicap, or age. OMA monitors the requirements of these statutes in federally assisted programs, direct assistance programs, and employment programs of the Department.

The Age Discrimination Act (ADA) was enacted by Congress in 1975 as an amendment to the Older Americans Act. The Office of Minority Affairs has responsibility for development of USDA implementing regulations. Although the ADA would appear to exclusively protect the elderly, its protections are extended to members of all age categories. Final USDA regulations implementing the ADA have been issued on June 1982.

In May 1976, the provision of the Age Discrimination in Employment Act (ADEA) of 1976, were extended to include Federal, State, and local governments. The ADEA prohibits employment discrimination and protects persons between the ages of 40 and 75.

SCIENCE AND EDUCATION ADMINISTRATION

Three agencies, Agricultural Research Service, Cooperative State Research Service, and Extension Service, allocated and expended appreciable resources to research and education projects and programs to benefit the aging. Highlights from each agency follow.

AGRICULTURAL RESEARCH SERVICE

The Family Economics Research Group of ARS conducts research to develop new knowledge on the levels of living attained by families and on the effects of various household management practices on maintaining or improving economic well-being. Knowledge of the time and money resources available to families (including the older population) and the decisions families make in using these resources to provide goods and services for their members makes possible the development of research materials that can be used to help families become more self-sufficient and to enhance their ability to cope with economic and other stress. These materials are developed primarily for use by Extension home economics programs in family resource management. Work in the area of aging has included the following:

(1) *Research-based guidance materials.*—Major revision of popular publications on budgeting and financial planning. The completed work tentatively titled "Budgeting: A Tool for Managing Personal and Family Resources," will include sections on the lifelong process of financial planning for retirement and on managing resources

during retirement, and will also include examples of income and expenditures typical among retired families.

(2) *Reports on issues related to aging.*—Three articles published in Family Economics Review (a quarterly publication of the USDA) provide trend and outlook information. These include: Hefferan, C., "Retirement Income," Family Economics Review, winter 1981, pp. 3-12. Pitts, J., "Economic Well-Being of the Elderly: Recommendations From the White House Conference on Aging," Family Economics Review, October 1982, pp. 23-27. Schwenk, F., "Pensions," Family Economics Review, spring 1981, pp. 8-13.

(3) *Participation in a forum on aging sponsored by the Center for the Family American Home Economics Association.*—A staff member served on the planning committee, and developed information for a slide presentation for the June 1982 forum on "Whose Responsibility? Economic Realities of the Aging Population." The proceedings from the forum will include an article on "Strategies in Financial Planning for Retirement" written by staff members of the Family Economics Research Group.

COOPERATIVE STATE RESEARCH SERVICE

The Cooperative State Research Service (CSRS) administers Federal grant funds for research in the food and agricultural sciences, including social, economic aspects of the sciences in the broadest sense. Funds are made available to the State agricultural experiment stations, the 1890 land-grant universities, other designated State institutions in the 50 States, Puerto Rico, Guam, the Virgin Islands, the District of Columbia, Micronesia, and American Samoa. CSRS also administers a specific grant program for research on special problems in agriculture.

In a CSRS regional research project, scientists from two or more States work cooperatively to increase the efforts devoted to a problem. A number of regional research projects have been and are being focused on problems of the elderly. Scientists have studied the nutritional status of the elderly and factors related to it, such as lifestyle, cultural group membership, physiological and psychological changes of aging and participation in Federal food and nutrition programs.

In order to improve the quality and kinds of community services for the elderly, regional research projects have been directed toward evaluation of current services. National and local programs and their availability to different groups of elderly, such as rural and urban, have been examined. Programs for care of the elderly in nursing homes and their own homes, quality of life of the elderly, formal and informal support networks and the accessibility of needed services have been the focus of research projects. The lack of adequate transportation, and inadequate income, and inadequate housing are major problems of the rural elderly, according to the researchers.

Scientists in various States have also conducted research about the elderly and their needs. Food choices and habits, clothing designs for individuals with impaired physical abilities, and the thermal qualities of textiles have been studied. Individual researchers have conducted studies about housing design and problems of the elderly, consumer problems, and the roles the elderly occupy in their families and communities.

The results of these research projects have been presented to individuals and agencies who work with the elderly. The research conducted has provided information to individuals and agencies to utilize in improving the lives of elderly citizens.

EXTENSION SERVICE

Program leaders in Extension provide national leadership for the Cooperative Extension Service staffs in 50 States, District of Columbia, Guam, Puerto Rico, the Virgin Islands, Micronesia, and American Samoa. Included are the State and county staffs of both the 1862 and the 1890 institutions. A particular highlight in 1982 was a "National Extension Workshop on Aging." Thirty-four leaders from 25 States, Guam, Puerto Rico, and the national office participated in the 4-day program and staff development training program. Such sessions, generally conducted on a 5-year cycle, enhance the quality of programing for the aging.

National program leaders continue to join forces with the public and private sectors working with the aging. Notable are: The American Council of Life Insurance, American Association of Retired Persons/National Retired Teachers Association, National Council on Aging, American Home Economics Association, National Safety Council, the Administration on Aging, Office of Consumer Affairs, National Institutes of Health, and National Institute on Alcohol Abuse. Other activities and programs are reported below for three Extension Service program units.

Natural Resources and Rural Development

This unit program provides education in leadership and organization development, business and economic development, and also community services such as health care and transportation.

At the request of *Guam's* Services to the Elderly Bureau, Extension developed skits for seniors to enact at Guam's 16 senior citizen centers. About 80 percent of the island's elderly have improved their leadership and communications skills through performance of these skits.

Pennsylvania elderly receive a newsletter to assist them in marketing their handicrafts and shift as crafts producers from hobby to professional status.

Extension assists Lady Slippers Designs, a *Minnesota* soft sculpture cottage industry. Many of the industry's sewers are elderly. Extension provides organizational education to the industry, which as a result is relying less on outside financial support and more on self-generated revenue.

Missouri Extension with the Agricultural Experiment Station has developed a budget analysis tool for local decisionmakers in the rural Ozarks to use in determining the potential need for nursing homes and estimating investment capital and operating costs. This tool was published as U.S. Department of Agriculture Information Bulletin No. 437, "Nursing Home Feasibility Guide for Local Decisionmakers in Rural Ozarks."

Oklahoma Extension and the Agricultural Experiment station developed a computer program for local decisionmakers to use in analyzing costs and returns for transportation systems for the elderly. The research was funded by the Farmers Home Administration. The report, "User's Guide to the Computer Program for Analysis of Cost and Returns for Transporting Systems for the Elderly," was published by Oklahoma State University as Research Report P-808, May 1981.

4-H and Youth Development

Intergenerational programs involving youth and aging are a significant part of the 4-H program. Older Americans serve as 4-H leaders to groups of youth. They teach subject matter such as animal care, plant science, sewing, cooking, gardening, and food preservation.

Retired people share their work experiences with youth and discuss career opportunities. A popular program in the Arlington County, Va., 4-H has been "What's My Career" where a panel of aging told of things they did when working and the youth guessed their occupations. This was followed by questions and discussion.

Older adults are very active in working with youth in 4-H activities. They assist with camps, talent shows, speech, and demonstrations and serve as judges for 4-H events. The Master Gardener, Master Fix It, Master Shopper, and Master Food Preserver programs attract many retired people who work with both youth and adults in their areas of interest. These volunteers receive in-depth training and are certified to teach others.

Youth also help the aging. The adopt-a-grandparent program is very active in several States. They become good friends, share experiences, and help care for their aging adopted partner. A 4-H club in *Michigan* has adopted an aging woman who they help with chores and in turn she teaches them projects.

4-H youth team up with the aging in community watch, crime prevention campaigns and safety programs. In Santa Rosa, Calif., 4-H youth and older people work together on joint garden plots. The program is called common ground, and publications are available in English and Spanish.

In *Michigan,* there is no age restriction in many counties, so the aging form 4-H clubs, select projects, attend camp at Camp Kett—the State 4-H center, and exhibit at fairs. In some of the counties the 4-H clubs for the aging are organized and led by senior 4-H members.

As members of the University of Southern California, *California,* Ethel Percy Andrus Gerontology Center Advisory Committee on "Aging," several national 4-H program leaders supported the successful funding and development of the four series film on aging. The "Prime Time" films were designed for young people to understand and appreciate the older generation including: Coping with change, learning to enjoy, inner strengths, and interdependent relationships. The films were introduced at a congressional reception and received national endorsement.

Home Economics and Human Nutrition

Extension Home Economics programs provide education that assists the aging in maximizing stability and security throughout the life cycle. People learn skills, increase competencies, and come to recognize the choices for adjusting to economic and social change. With increasing visibility of the elderly and the special needs of this growing segment of the population, all State Extension Home Economics staffs are actively providing educational programs to the aging and selected program examples are given below:

Financial Management

Since 1976, a *Texas* program "Setting Your Household in Order," has helped senior citizens and other audiences develop a recordkeeping plan for their households. In 1981, volunteer leaders conducted estate and financial planning seminars for 596 senior citizens.

North Carolina Extension Home Economists in 15 counties conducted programs for 8,301 mature persons on how to make a will and update their estate plans.

A *Montana* study-at-home course on estate planning has been used by 20,000 citizens, many of them elderly. (The course had been designed cooperatively with personnel from the State bar, Montana's Inheritance Tax Division, the Internal Revenue Service, and law department of the University of Montana.)

Elderly numbered prominently among the 6,135 participants in the *District of Columbia's* consumer education programs on shopping, income tax, recordkeeping, and unit pricing. This multiagency program was coordinated by the Metropolitan Extension Council, Consumer Credit Counseling, the Department of Recreation, WKYS radio, churches, senior nutrition centers, and the UDC-Consumer Affairs Office.

A *Missouri* volunteer program in one county assisted 100 low-income elderly to apply for property tax refunds under the State's circuit breaker law. The refunds averaged $66 per person.

Clothing and Textiles

Programs on clothing adjustments for the disabled and elderly were conducted by 150 volunteer leaders and reached 500 elderly in *Illinois*.

Five new *Virginia* publications on clothing management for persons with physical limitations are benefiting many of Virginia's elderly.

Clothing care (stain removal techniques) was taught to 89 senior citizens in *Missouri*.

Energy

A *Pennsylvania* county planned a program on the thermal properties of clothing to reduce household heating and cooling expenses: 11 radio programs were broadcast on six stations, and articles were written for newsletters with a circulation of 5,000.

Arkansas senior citizens attending Extension programs have saved an average of $172 per year on fuel costs by learning about appliance efficiency and home environment management.

Two hundred *Washington* State senior citizens learned ways to conserve energy in their homes.

Virginia teaches elderly with a three-lesson series "Living with Energy Limits"—ways of dressing warmly, checking air leaks in the home, and saving money with home appliance management.

Elderly were part of the readership of a six-part *Michigan* newsletter on weatherization, insulation, wood burning, solar energy, and appliances and automobile use.

Eighty-two seniors in *West Virginia* received a six-series newsletter on increasing skills in the use of microwave ovens.

Missouri elderly enrolled in a microwave correspondence course and others also received education on energy-efficient window treatments through programs planned jointly with Extension, engineers, builders, retailers, the Departments of Natural Resources and of Energy, and the State Office on Aging.

Home Repairs

Elderly attended many of the 356 workshops on emergency and home repairs conducted by the *District of Columbia*. Savings ranged from $50 on minor repairs to $150 for insulation work. Extension how-to-weatherize-the-home kits have been issued to certain low-income elderly homeowners.

Michigan offered 2,550 elderly home-repairs-skills-training, which extended their income about $568 per household.

Family Life

A meeting for elderly and other occupants of a troubled government housing project was part of a *Texas* program to decrease teen-related problems and increase strengthening parent-teen relationships.

Five thousand copies of an Extension publication were distributed to *Missouri* clergy to help them understand the needs of the elderly in their congregations. This was a cooperative effort involving Lincoln University Cooperative Extension, Missouri Division of Aging, Missouri Council of Churches, and the Missouri State Library. Other *Missouri* workshops and seminars trained 280 persons to better understand and relate to mentally disoriented elderly.

Texas Extension home economists trained persons as competent caretakers of ill elderly and trained 162 older persons for part- or full-time employment, or to provide a source of help to community members needing babysitters.

"Butterberry Hill," a television series for elders and children was created and transmitted to about 13,000 homes each month on an NBC-affiliate station in Topeka, *Kans.* Also, nine 30-minute programs were accompanied by teacher guides, which were used in at least 125 classrooms; the programs reached at least 5,000 children each month. And a *Kansas* "pick-up" packet titled "Grandparenting: A Gift for Generations" was distributed to 1,500 leaders and 12,000 elders. Also, a play, "My Grandfather, My Son," about grandfathering was performed before 1,500 parents and grandparents.

Since 1978, *New York* has been providing "competency" (daily living) assistance to approximately 90 elderly former residents of psychiatric institutions each month through cooperative work with the Utica area multiagency Community Support System. Approximately, 250 different people were aided by Extension in the 12 months.

Health

A special program was implemented in LaSalle County, *Ill.*, to help senior citizens consolidate their medications and physicians' instructions in a common location—the refrigerator—for use by emergency medical personnel in the event of crisis. Five thousand "vial of life" packets were distributed at township meetings, the county fair, senior citizens meal sites, and door-to-door with the help of members of the county rescue squad.

A health fair in Stark County, *Ill.*, screened 90 senior citizens for previously undetected signs of chronic illness. The results: 33 chronic disease suspects were identified, and the free services provided to senior citizens saved the elderly $38,000. The county home economics adviser had coordinated the efforts of 60 health professionals and other volunteers from the Red Cross, the County Council for Senior Citizens, County Health Center, and the National Health Screening Council for Volunteer Organizations.

At the Sioux City Indian Center and at five county congregate meal sites for *Iowa* elderly, volunteers and homemaker health aides taught 1,200 elders about medicaid and dispelled their general confusion on the kind of supplemental health insurance coverage needed. The volunteers were from the Siouxland Interstate Metropolitan Planning Council, area agency on aging, the AID Center, and Woodbury County Community Action Agency.

Fillmore County, *Nebr.*, held screening clinics, a health forum, and nutrition seminars for elderly; Adams County held a grief seminar and coordinated grief-support groups of interested persons.

Texas holds health fairs with free health screening in 33 of its counties. Resources include representatives from private and government health agencies, local hospitals, and emergency care organizations.

A *Wyoming* newsletter on food and drug interactions gave the aging information on how foods can react with certain prescription and over-the-counter drugs to make the drugs useless or dangerous.

A *Texas* program on the dangers of drug interactions increased the knowledge of 250 older citizens. Resource persons included staff members of the University of Texas College of Pharmacy.

Nutrition

District of Columbia exercises and nutrition sessions were run by six Extension-trained volunteers. These workshops were conducted in cooperation with churches, libraries, recreation centers, and senior nutrition centers. Elderly were among the 5,920 adults attending.

Kentucky taught 900 senior citizens how to lower their sodium and sugar intakes.

Extension-trained volunteers in *New Hampshire* taught 200 elderly and other homemakers how to reduce salt in their diets. Within 4 months after the program, 70 percent had reduced their sodium intakes.

Montana developed a program on diet and health which reached 65 elderly.

A *Maryland* program on the five food groups reached 439 senior citizens at senior center sites. Extension trained 10 agents and coordinators of the sites. These 10 helped to take and computer process the dietary intakes of the senior citizens. Subsequently, 186 of the elders learned how to improve the nutritional soundness of their diets.

A *Missouri* lesson series for senior citizens living alone taught 37 senior citizens food preparation techniques and nutrition facts. Ninety-two percent reported an increased intake of calcium, iron, and protein-rich foods as a result of the lesson series.

National Extension Homemakers Council, Inc.

National Extension Homemakers Council (NEHC) is composed of 514,000 members in 31,540 clubs in 44 States, Puerto Rico, and Virgin Islands. Members of this organization are a clientele and support group of the Extension Service and 29 percent are over 65 years of age. Members participate in Extension's educational progams to improve their own quality of life. In addition many community services are initiated and provided. Such as:

Mississippi Extension Homemakers made 5,189 visits to nursing homes, organized and support a homemakers club for nursing home residents and conducted educational programs on clothing adaptations for the handicapped. Homemakers in over 150 counties in *Texas* are promoting and implementing countywide "vial of life" projects to protect the health of aging residents.

ITEM 2. DEPARTMENT OF COMMERCE

DECEMBER 23, 1980.

DEAR MR. CHAIRMAN: Thank you for your letter regarding Department of Commerce (DOC) programs pertaining to older Americans.

Enclosed is the Department's report for 1982, detailing five agencies' programs which benefit the older population, to be placed in "Developments in Aging, part 2." Since many of these programs are included in the general activities of the agencies, expenditures devoted specifically to aging-related issues are not always available.

Sincerely,

MALCOLM BALDRIGE, *Secretary*.

Enclosure.

1982 REPORT ON AGING

BUREAU OF THE CENSUS

Current Population Report

	No.
Series P-20:	
Fertility of American Women: June 1981 (advance)	369
Voting and Registration in the Elections of November 1980	370
Households and Family Characteristics: March 1981	371
Marital Status and Living Arrangements: March 1981	372
Population Profile of the United States: 1981	374
Fertility of American Women: June 1980	375
Households, Families, Marital Status, and Living Arrangements: March 1982 (advance)	376
Series P-23:	
Coverage of the National Population in the 1980 Census by Age, Sex, and Race: Preliminary Estimates by Demographic Analysis	115
Ancestry and Language in the United States: November 1979	116
Wage and Salary Data from the Income Survey Development Program: 1979	118
Selected Characteristics of Persons in Environmental Science: 1978	119
Selected Characteristics of Persons in Mathematical Specialities: 1978	120
Series P-25:	
Projections of the Population of Voting Age for States: November 1982	916

	No.
Series P-25—Continued	
Preliminary Estimates of the Population of the United States, by Age, Sex, and Race: 1970 to 1981	917
Projections of the Population of the United States: 1982 to 2050 (advance)	922
Series P-60:	
Characteristics of Households and Persons Receiving Selected Noncash Benefits: 1980	131
Money Income of Households, Families, and Persons in the United States: 1980	132
Characteristics of the Population Below the Poverty Level: 1980	133
Money Income and Poverty Status of Families and Persons in the United States: 1981 (advance)	134
Characteristics of Households Receiving Selected Noncash Benefits: 1981 (advance)	135

Other Reports, Papers, and Continuing Work

Preparation of a report on "The Demographic and Socioeconomic Aspects of Aging in the United States," based on the most recent available data, for publication in series P-23.

Paper, "Net Migration of the Elderly, 1960-1970 and 1970-1980: A Methodological Analysis," presented at 1982 American Statistical Association.

Continuing work on estimates of coverage of the older population in the 1980 census and completeness of enrollment in medicare; comparison of mortality of elderly as measured by Medicare and the National Center for Health Statistics.

Continuing work on preliminary evaluation of centenarians in the 1980 census.

Background document was prepared and will be published on behalf of the World Health Organization on the "Demographic Factors Affecting the Health of the Elderly in the Year 2000 and Beyond," for the U.N. World Assembly on Aging held in 1982.

The Census Bureau is continuing its research on methods of projecting mortality in the United States.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

The National Weather Service of the National Oceanic and Atmospheric administration (NOAA) provides a daily weather forecast and warning service which is useful to all citizens and extremely important to the elderly. The forecasts of severe storms, extreme heat or cold, floods, tornadoes, hurricanes, and conditions favorable for high levels of air pollution provide advance information which helps older citizens plan and act in ways to avoid predicted weather that could be hazardous.

The National Environmental Satellite, Data, and Information Service (NESDIS) provides many informational products and services that have particular application for the elderly.

Health

Many illnesses and causes of death among the elderly, such as emphysema, chronic obstructive lung diseases, and heart stroke, are climate related. NESDIS provides climatic data, bibliographic information, and general consultation services to the Center for Disease Control researchers and other physicians or foundations.

Weather Stress

NESDIS also produces a weather stress index (WSI). The index incorporates temperature, humidity, and windspeed to indicate weather-related stress on human activities. Days and regions with severe or extreme weather stress can be identified nationwide and the impact on human health assessed.

Relocation

An elderly person's relocation sometimes is planned for health purposes. Information about the type of weather likely to be encountered in the new area can be useful in the decisionmaking process. One way of obtaining information about the climate of an area is to obtain publications or other material prepared by NESDIS, which contain summaries of weather elements over a period of years. This information is available in a variety of forms, for both individual stations and groups of stations within the United States and worldwide.

Energy Costs

Energy consumption estimates are included in the periodic NESDIS publication, "U.S. Climate Impact Assessment." This information is useful for early Government identification of regions in the United States that would require additional support to counter abnormal energy costs due to weather extremes. Also, the information could be useful to the elderly population to plan their utility bills for heating during the winter and cooling during the summer.

A special energy assessment was presented by NESDIS to the Senate Committee on Aging, Subcommittee on Health and Long-Term Care on February 3, 1982. The assessment estimated the magnitude of increased heating costs around the country resulting from the cold winter of 1981-82.

Recreation

NESDIS, in partnership with Sea Grant, prepares recreational brochures and a water temperature guide that are popular with senior citizens. The brochures now are available for coastal Delaware, Lake Erie, southern New Jersey, Lake Ontario, coastal Mississippi, coastal North Carolina, Puerto Rico, Rhode Island, and San Francisco Bay. The water temperature guide is for Atlantic beaches. These products can be valuable planning tools for those who are retired on a fixed income and can take advantage of out-of-season rates.

NATIONAL TELECOMMUNICATIONS INFORMATION SERVICE

National Telecommunications Information Service (NTIS) is the central source for the public sale of U.S. Government-sponsored research, development, and engineering reports, including the social sciences, and specifically reports on aging and the elderly. Subject analysts make up annotated bibliographies by searching the NTIS data base. The two bibliographies available are: "The Elderly: Social, Health, and Transportation Problems and Services," (5 volumes) and "Transportation for the Elderly or Physically Handicapped," (2 volumes). These volumes are updated annually.

A fiscal year 1982 agreement between the National Telecommunications Information Service and the Administration on Aging (AoA) is currently being renegotiated. Under this agreement NTIS will promote, disseminate, and sell all AoA publications emanating from the AoA for which permission has been obtained. NTIS will also prepare and sell a title index of all AoA publications described above. This agreement will cover the microfilming and distribution of such materials to depositories throughout the United States. The continuation of this agreement is dependent on AoA's acceptance of NTIS' performance cost and funding availability.

PATENT AND TRADEMARK OFFICE

The Patent and Trademark Office maintains a program which permits a patent applicant who is 65 years of age or older to have the examination of their patent application accelerated. The patent application can be given this special handling upon a showing, as by a birth certificate or the applicant's affidavit or declaration, that the applicant is 65 or older.

Normally, new applications are examined by the Patent and Trademark Office in the order of their effective U.S. filing dates. In the case of accelerated examination, the application is examined as soon as the request for acceleration is granted.

NATIONAL BUREAU OF STANDARDS

Fire Research and Safety

Both the Health Care Finance Administration (HCFA) of the Department of Health and Human Services and the National Fire Protection Association's Life Safety Code have adopted the NBS fire safety evaluation system (FSES) for health care facilities. The system has also been cited by the President's Committee on Regulatory Reform as a desirable approach to the objective of improved, less restrictive regulations. As an analytical tool, the system determines if a hospital or nursing home has the level of fire safety protection prescribed by the Life Safety Code. When retrofit of an existing building is required, the system permits more flexibility than a prescriptive code in selecting the fire protection features to be used in obtaining the needed level of fire safety. This flexibility frequently results in significant cost savings without sacrifice of safety for both upgrading existing buildings and in the design of new buildings or major renovations.

The final report on a special FSES covering community-based residential care facilities is nearing completion. Such facilities serve the aged and other special groups (e.g., developmentally disabled) which do not need the degree of care or restraint and high costs of formal institutions. Some of these facilities have recently been involved in disastrous and tragic fires. The system covers a wide range of building sizes, residential needs, and levels of care required. NBS has submitted a proposal to the National Fire Protection Association to include a new classification of occupancy specifically recognizing these residences in the Life Safety Code. The submission contains recommended fire safety requirements for this occupancy along with the evaluation system. The NFPA is moving quickly in its consideration of the system.

In connection with the above work, NBS has just published a comprehensive guide to fire emergency planning for board and care homes. This manual provides those who own and operate such homes with sound suggestions in easily readable form for developing fire emergency strategies.

Dental Materials

NBS research in dental materials has been directed toward developing composite materials with greater durability and wear resistance and toward improving base metal alloy alternatives to the costly gold prosthesis. Current efforts are directed, in part, toward upgrading the quality of composite restorative materials with regard to durability, adhesiveness, storage stability, and color. A silver staining technique developed in a study of wear mechanisms in restorations is yielding promising results. This technique differentiates between the effects of wear observed in clinical samples and those produced under laboratory accelerated test conditions. Current research has demonstrated the critical role of composite restorations to minimize softening of the resin matrix by food debris and select oral fluids. In addition, work is continuing on the development of new alloys and ceramics, the fusion of ceramics to base metals, and on the deterioration of dental amalgams. NBS staff also made significant contributions as members of American Dental Association committees that develop voluntary standards for dental materials.

Synthetic Implants

Bureau scientists are conducting research on the properties and performance of a number of alloys for use in metallic surgical implants. Special emphasis is being placed on how the performance of cobolt-chromium-molybdenum alloys and titanium alloys is affected by processing variables. Further, test methods are being investigated for characterizing the porosity of polymeric implant materials. The wear and fracture resistance of polyethylene hip implants is being measured under a variety of static and fatigue loading conditions. The relationship between the mechanical properties of the implant material and the processing methods used to fabricate the implant device will be determined. Investigations into potential methods for improving the bone cement used for fixation of orthopedic implants has proceeded. Attention has been primarily focused on interface properties and reduction of the tissue damaging exothermic temperature rise on curing. In addition, NBS staff made significant contributions to a number of voluntary standards groups during fiscal year 1982, especially the American Society for Testing and Materials F-4 Committee on Medical and Surgical Materials Devices.

Listed below are the expenditures during fiscal year 1982 for these programs (in thousands of dollars):

Programs:	
Fire research and safety	$390
Dental materials	845
Synthetic implants	500
Total	1,735

ITEM 3. DEPARTMENT OF DEFENSE

JANUARY 19, 1983.

DEAR MR. CHAIRMAN: Thank you for your letter requesting a report on Department of Defense (DOD) actions and programs related to aging.

This Department continues to operate a comprehensive retirement planning program for Defense Federal service employees. Integrated into the overall personnel management process, our program is designed primarily to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. It encompasses extensive preretirement counseling for employees (and their spouses in many instances) on such subjects as financial planning, health needs, leisure time activities, living arrangements and personal guidance. The program also includes trial retirement and gradual retirement options for employees where feasible. We believe our program helps alleviate many of the problems that employees have encountered in the past when approaching retirement age. We expect to continue the operation of this program in 1983.

The military departments and the Defense agencies, in cooperation with community health officials, continue to provide a number of occupational health programs and services to employees, and in some cases to former employees who have retired. Many of these programs and services are designed to address problems generally associated with increasing age Included are health guidance and counseling, periodic testing for diseases and disorders, immunizations and treatments.

Within DOD, we continue to eliminate discrimination based upon age. We are examining personnel policies, practices, and procedures for possible conflict with equal employment opportunity intent, including discriminatory use of age.

In summary, this Department has operated a comprehensive retirement planning program for civilian employees, provided extensive health care services to employees and carried out a positive program to preclude discrimination based on age. These program efforts will be continued in 1983.

Sincerely,

JERRY L. CALHOUN,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy and Requirements).

ITEM 4. DEPARTMENT OF EDUCATION

DECEMBER 28, 1982.

DEAR MR. CHAIRMAN: Thank you for your letter requesting current information from the Department of Education to be included in part 2 of "Developments in Aging," the annual report of the Senate Special Committee on Aging.

Enclosed is a summary of programs administered by the Department's Offices of Vocational and Adult Education; Bilingual Education and Minority Languages Affairs; and the Rehabilitation Services Administration, which provide assistance to eligible older Americans.

If I may be of further assistance, please let me know.

Sincerely,

T. H. BELL, *Secretary.*

Enclosures.

ADULT EDUCATION

The U.S. Department of Education is authorized under the Adult Education Act, Public Law 91-230, as amended to provide funds to the States and outlying areas for educational programs and support services benefiting all segments of the eligible adult population. It is the purpose of the act to encourage the establishment of programs of adult education that will enable adults 16 years of age and older:

(1) To acquire basic skills needed to function in society; and

(2) To assist them in continuing their education until completion of secondary level, if they so desire.

Those adults who have completed the secondary level but are functioning at a level below are eligible to participate in the program. Students seeking employability skills are also given the means to secure training which will help them to become more employable, productive, and responsible citizens. Federal funds support up to 90 percent of each State's program and up to 100 percent of the program in outlying areas. At least 10 percent of each State's allotment must be used for special experimental demonstration projects and teacher training. In addition to the State-administered program, the act authorizes educational programs for adult immigrants, which are currently unfunded. Two other provisions of the act, planning grants to States and a national development and dissemination program, were included in the 1978 amendments to the act. At present, these authorities are also unfunded.

In order to discuss the specifics of the efforts aimed at older adults, one must first be aware of the demographic changes which have a profound impact upon the efforts. According to the 1970 census, the median age of the population in that year was 27.9 years. By 1990, the median age is expected to rise to 32.8 years. This "graying" of the U.S. population will inevitably continue for several decades after 1990.

The education of older persons has rarely ranked high as an educational priority in the United States, but the 1970's may well be considered the decade of growth in educational geronotology. Demographics have tended to make this development inevitable. Furthermore, nearly half of the 15.6 million adults 70 years old and over, and about 36 percent of the 8.6 million adults aged 65 to 69, have had 8 years of schooling or less (1980 census data). Such a high incidence of under-education indicates the need for emphasizing effective basic and coping skills in programs for older adults.

The adult education program which is led by OVAE at the national level is charged with addressing these needs. The number of participants nationally in the program indicates the extent to which this program reaches those with the needs. In 1980, the total number of participants in the program was 2,057,982. Of these, 266,907 were between 45 and 64 years of age and 130,757 were 65 years and older. In 1981, the total number of participants had increased to 2,278,526. The number of participants in the 45 to 59 year range was 28,995 and that of the group 60 and older was 144,894. Therefore, the number of participants aged 45 or older increased 7 percent between 1980 and 1981. There is, then, clearly a demonstrated need for the program.

The adult education program addresses the needs of the group by emphasizing functional competency rather than grade level objectives. Special projects improve services for older persons through individualized instruction, use of media, home-based instruction, and through curricula focused on coping with daily problems maintaining health, managing money, using community resources, understanding government and participating in civic activities.

Equally significant is the expanding delivery system, including radio, television, and courses by newspaper, as well as clearing-houses and satellite centers designed to overcome barriers to participation. Where needed, supportive services such as transportation and lunch are provided as well as outreach activities adapting to the life situations and experiences of older persons. Self-learning preferences are recognized and assisted by providing information guidance and study materials. To reach more older persons, adult education programs go into senior centers, nutrition programs, nursing homes, retirement centers and day centers.

Another tool OVAE has developed to help carry out this program is a memorandum of understanding with the Administration on Aging at the U.S. Department of Health and Human Services. The intention of this memorandum of understanding is to foster closer coordination between the network of organizations providing services to the Nation's older people, and educational organizations and institutions responsible for providing adult education opportunities. To achieve this goal, several objectives have been identified: (1) To increase awareness of the need to expand educational opportunities for older people; (2) to disseminate information about existing model efforts underway in order to encourage their replication; (3) to identify opportunities for establishing or strengthening links between these two systems; (4) to encourage the expansion of educational opportunities which will strengthen the capacity of older people to maintain their independence; and (5) to pursue special activities to provide home-based educational opportunities using appropriate technological approaches.

Under this agreement, State agencies on aging and State educational agencies will receive information developed jointly by OVAE and the Administration on Aging. As efforts are made at the national level to collaborate in this major effort, it is important that similar efforts be made at both the State and local levels. Organizations involved will represent a variety of public and private educational organizations and institutions and organizations serving older people.

In conclusion, the national adult education program for older Americans will continue to seek to meet the learning needs of a growing number of older Americans. Increased cooperation among the organizations, institutions, and community groups involved in this area at national, State, and local levels should lead to increased sharing of resources and improved services.

BILINGUAL VOCATIONAL TRAINING

Support for bilingual vocational training was first authorized under the Education Amendments of 1974 which added part J to the Vocational Education Act of 1963. The Commissioner was authorized to support projects which would provide bilingual vocational training to persons of any age who were both individuals of limited-English speaking ability (LESA) and also either unemployed or underemployed. Because of their language handicap, these individuals were unable to benefit from English-language vocational training.

The Education Amendments of 1976 expanded the authority to include not only bilingual vocational training but also bilingual vocational instructor training and the development of bilingual vocational instructional materials, methods and techniques. The appropriation is distributed among the three programs: 65 percent is allocated to bilingual vocational training projects, 25 percent for bilingual vocational instructor training projects and 10 percent is used for the development of materials. In fiscal year 1983, the appropriation available is $3,686,000.

The purpose of the program is to provide bilingual vocational training and job-specific English language instruction to out-of-school youth and adults of limited English-speaking ability.

Funds available to the Secretary of Education will be used to fund approximately two projects in bilingual vocational training and one project in bilingual vocational instructor training. Training allowances for participants in bilingual vocational training programs are subject to the same conditions and limitations as set forth in section III of the Comprehensive Employment and Training Act of 1973. (29 CFR 95.34) This amounts to approximately the minimum hourly wage times the number of hours in class that a participant attends.

PROGRAM OPERATIONS

Under this authority, the Secretary makes grants with eligible agencies, institutions, and organizations in providing job training in recognized and in new/emerging occupations. Instruction in job-specific English language is included to insure that participants may find employment in environments where English is the language normally used. Eligible public or private institutions or other eligible agencies may also receive grants to train instructors of bilingual vocational training (BVT). This training prepares persons to participate in bilingual vocational training or vocational education programs as instructors, aides, or other ancillary personnel, such as job counselors or job placement specialists.

PROGRAM SCOPE

Twelve bilingual vocational training programs in seven States are training 1,062 persons for employment in occupations during fiscal year 1982. Occupations include: hospitality and food services, housing maintenance and repair, chefs, data entry operators, air-conditioning and heating technicians, auto mechanics and electricians.

The essential aspect of a bilingual vocational training program is that the training must be conducted both in English and the dominant language of the trainees. Participants must acquire sufficient competence to enable them to perform satisfactorily in a work environment where English is used.

Six bilingual vocational instructor training programs have been funded to provide preservice and inservice training for about 203 teachers and staff.

OLDER AMERICANS

These programs serve limited English-speaking adults who are underemployed and need upgrading of their skills in order to advance. Other participants are unemployed and need training in new skills. Older Americans are encouraged to apply to programs such as: Chinatown Manpower Project, Inc. (New York City) for training in the fundamental principles of accounting or to Houston Community College for training to repair air-conditioning units.

PROGRAM EFFECTIVENESS AND PROGRESS

The bilingual vocational training program reduces unemployment rates, increases job earnings and increases the rate of labor force participation of limited-English speaking adults. Studies continue to show that these programs have an 85 to 100 percent job placement rate with repayment of training costs within a one to three year period through Federal and State taxes on income earned.

REHABILITATION SERVICES ADMINISTRATION

PROGRAM OPERATIONS

Basic Vocational Rehabilitation Program

The Rehabilitation Act of 1973, as amended, authorizes the allocation of Federal funds on formula basis with a 20 percent State fund matching requirement (80 percent Federal/20 percent State) for the administration of a program of wide-ranging services to assist disabled individuals to prepare for and engage in gainful occupations. The agency follows the intent of statute to provide services to individuals with the most severe handicaps. The Federal share was $817,484,000 for fiscal year 1980.

Caseload Activity in State VR Agencies

A summary of caseload activities in VR agencies for fiscal year 1981 is characterized by the following:

(1). A decline in the total number of persons applying for services from, and becoming clients of, State VR agencies.

(2) A decrease in the number of persons rehabilitated; and

(3) An increase in the number and proportion of severely disabled persons among the total caseload, with some indication that the influx of those with severe disabilities is tapering off.

Services to the Blind and Visually Handicapped

The 1978 amendments to the Rehabilitation Act created a new section which provided for special projects to serve older blind persons. During fiscal year 1981, there were seven projects in operation serving this population.

An evaluation of vocational rehabilitation programs providing services to blind and visually handicapped people include:

(1) Serving blind and visually handicapped clients in specialized caseloads made up entirely of these disability groups.

(2) Questioning the assumption that combined agencies are more cost effective.

(3) Providing more extensive in-service training to rehabilitation counselors and regional office staff; and

(4) Strengthening communications among Federal, regional, and State components of the vocational rehabilitation system which serves the blind and visually impaired clients.

Strong efforts have been made to develop and expand job opportunities for blind and visually disabled persons in both traditional and innovative areas including: Tax service specialists, computer programers for the Army, and prevocational adjustment training in a postsecondary educational facility.

Helen Keller Center for Deaf-Blind Youths and Adults

The Helen Keller Center for Deaf-Blind Youths and Adults continues to make positive strides in rehabilitating persons with these disabilities. As a result of training at this center, trainees were placed in professional employment, sheltered workshops[1] and/or returned for additional schooling. In addition, the research program is concentrating on the development of testing aids and appliances to assist deaf-blind persons become more self-sufficient. The center is also further developing the Wrist-Com, a miniaturized, waterproof and shock resistant wireless device worn on the wrist that receives vibratory signals from a special transmitter.

Special Projects for Severely Disabled Individuals

In fiscal year 1981, eight new projects were initiated in the following areas of severe disability: Rheumatoid arthritis, learning disability cerebral palsy, multiple sclerosis, deaf-blind, mental retardation, and mental illness. In addition, three new spinal cord injury system projects were funded.

Handicapped Migratory and Seasonal Farmworkers

The Rehabilitation Services Administration coordinates services for handicapped migratory and seasonal farmworkers with the Department of Labor, the Public

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[1] Now referred to by the National Industries for the Severely Handicapped as "work centers."

Health Service, and the Office of Education. During fiscal year 1981, there were 13 active projects in 11 States in eight regions. The majority of persons served were of Hispanic background with the exception of the Florida project which served mainly black seasonal farmworkers. In fiscal year 1981, nearly 300 migratory and seasonal farmworkers were rehabilitated. A computer data system was also initiated which provides immediate data regarding eligibility and past services or wherever the migrant applies.

Randolph-Sheppard Vending Facility Program

The purpose of the Randolph-Sheppard Act is to provide qualified blind persons the opportunity to operate vending facilities on Federal and other property.

More than 400 blind persons enter this program each year. Historically, their earnings have increased yearly. Fiscal year data indicates that total gross income from this program was $243,822,781, with the average yearly earnings of vendors at $13,927 compared to $13,367 in fiscal year 1979.

SSDI and SSI Vocational Rehabilitation Programs

Sections 222 and 1615 of the Social Security Act provide for the payment from special Federal funds of costs of vocational rehabilitation services to disability and supplemental security income beneficiaries.

The expenditures decreased for these programs as follows:

	Fiscal year—	
	1980	1981
SSDI	$113,268,000	$87,050,000
SSI	55,000,000	37,000,000

The Omnibus Reconciliation Budget Act of 1981 (Public Laws 97-35) contained provisions which affect the rehabilitation of SSDA and SSI beneficiaries. Effective October 1, 1981, the provisions eliminate reimbursement from trust funds to VR agencies for rehabilitation services except in cases where the services have resulted in the beneficiary performing substantial gainful activity (SGA) for a continuous period of nine months. A precise definition of SGA has not been determined by the SSA.

Rehabilitation Facilities

Rehabilitation facilities provide the means for evaluation, treatment and training of many handicapped individuals who otherwise would not be rehabilitated. In fiscal year 1979, the most recent year for which data are available, State vocational rehabilitation agencies spent 33.9 percent of their funds for services to persons in these facilities. Since 1967, the utilization rates have made a dramatic increase from serving only 65,000 clients at that time, to serving 185,000 clients in 1979. This represents a remarkable 213 percent increase over a 12-year period.

National Industries for the Severely Handicapped (NISH), established in June 1974, reported that 713 work centers were certified and that the total value of commodities and services on the Federal procurement list that Government must purchase from the severely handicapped under the Javits-Wagner-O'Day Act increased by $14 million and now totals over $45 million yearly.

PROGRAM DEVELOPMENT ACTIVITIES

The focus of these activities is on the strengthening and improvement of service delivery in order to foster greater chances of vocational rehabilitation and independence of the handicapped person. The total appropriation for program development activities in fiscal year 1981 was $66,465,000.

Special Projects for Severely Disabled Individuals

In fiscal year 1981, eight new projects were initiated in the following areas of severe disability: Rheumatoid arthritis, learning disability cerebral palsy, multiple sclerosis, deaf-blind, mental retardation, and mental illness. In addition, three new spinal cord injury system projects were funded.

Handicapped Migratory and Seasonal Farmworkers

The Rehabilitation Services Administration coordinates services for handicapped migratory and seasonal farmworkers with the Department of Labor, the Public Health Service, and the Office of Education. During fiscal year 1981, there were 13 active projects in 11 States in eight regions. The majority of persons served were of Hispanic background with the exception of the Florida project which served mainly black seasonal farmworkers. In fiscal year 1981, nearly 300 migratory and seasonal farmworkers were rehabilitated. A computer data system was also initiated which provides immediate data regarding eligibility and past services or wherever the migrant applies.

Projects With Industry

The projects with industry program is a partnership between the rehabilitation and the business-industry communities to provide training leading to employment. In fiscal year 1981, over 50 projects affiliated with more than 2,500 private corporations were funded for $5,250,000. During this same time period, 10,000 disabled persons, most of whom were severely disabled, were served by this program. Of the total served, 7,000 were placed into competitive employment. It is estimated that $50 million in taxable wages were generated by this program in fiscal year 1981.

Special Recreation Programs

Eight 1-year projects were funded under section 311(a)(3) for a total amount of $1 million. Project activities funded under this program emphasize the site development and construction of recreational facilities accessible to handicapped persons.

Section 311(a)(3) of the Rehabilitation Act of 1973, as amended, provides a program of special projects and demonstrations for making recreation activities accessible to handicapped individuals. Eight 1-year projects were funded in September 1981 for a total amount of $1 million. The facilities assisted with grant support will provide a variety of activities to benefit and 29,000 persons.

Section 316 provides a program of projects for initiating special recreation programs for handicapped individuals. Twenty-five 1-year projects were funded in September 1981 for a total amount of $2 million. This program establishes recreational activities for handicapped persons in a community with special emphasis on expanding service for handicapped clients of State vocational rehabilitation agencies. The recreational activities carried out within these projects are diverse in scope and intended to contribute to the handicapped person's vocational potential. The activities cover indoor and outdoor sports, crafts, arts, hobby activities and therapeutic and physical development activities. Approximately 18,000 persons are expected to benefit from the projects funded in 1981.

Client Assistance Projects

Client assistance projects have the common goal of improving the VR program by providing ombudsmen to work directly with clients. There were 36 projects in operation during fiscal year 1981 at a funding level of $2,800,000.

Handicapped American Indian VR

The Navajo vocational rehabilitation program in Window Rock, Ariz., was awarded $650,000 in 1981 to carry out a bilingual rehabilitation service program aimed at returning the most severely handicapped Navajos to the world of work and independence. Approximately 600 severely handicapped Navajos are expected to receive service during the first year of operation.

Rehabilitation Training

Rehabilitation training grants are authorized to ensure that skilled workers are available to provide services to severely disabled individuals. Training was funded at $21,596,000 for fiscal year 1981. The scope of training was both long and short term and ranged from rehabilitation counseling to speech pathology and audiology. In addition, continuing education was provided to upgrade the skills of rehabilitation staff in public and voluntary agencies.

Special training projects of an experimental or innovative nature designed to train new types of manpower or demonstrate new techniques were also provided. In addition, there was a special program to train interpreters for the deaf. Emphasis continued to be placed on preparation of personnel for the provision of rehabilitation services to severely disabled persons, and was broadened to include independent living concepts and skills.

Independent Living

Independent living (IL) is a program to provide services to severely handicapped individuals with the nonvocational goal of being more fully functioning members of society. The appropriation for fiscal year 1981 was $18 million, increased from $15 million in fiscal year 1980. Of the three parts of this title (VII) only part B has been funded during this fiscal year. Part B provides for a project grant program under which the Commissioner makes grants to the State VR agency for the establishment of and operation of "independent living centers" which provide a wide range of services to severely handicapped persons.

Twenty-one new center for independent living projects were awarded funds in 1981. Five projects were continued. Since the program began in 1979, except for South Dakota, there is at least one center program in each of the 49 States, Puerto Rico, and the Virgin Islands. Forty-two percent of the 885 persons employed by these centers have some type of disability. Forty-four of the State rehabilitation agencies which have received grants have elected to contract with one or more local, community-based nonprofit agencies to administer center programs. Because of these contracts, there are now 132 federally assisted centers in the nation plus an additional 15 satellite or minicenters affiliated with a number of the more developed centers. A method for gathering uniform information about the severely disabled persons receiving services from the centers is being developed.

An evaluation study of the centers program concluded that the program had been implemented as intended both at the national and center levels. There is also evidence that disabled consumers are actively involved in management and policy development, and that disabled persons are employed by the centers, some of which had predominantly disabled staff. The study found that the centers visited were providing direct services, informational and referral services.

Regional office staff of the Rehabilitation Services Administration initiated periodic site-visits to center programs not only to monitor actual operations and progress, but to provide technical assistance to these newly emerging service programs. RSA regional and central office staff have participated in the conduct of regional or biregional conferences of center staff to identify and resolve operational and service issues requiring attention. A national conference was held in 1981 and was attended by 158 persons involved in the operation of community centers for independent living. Conference workshops included such topics as case management, financing center programs, attendant care, setting client and program goals, and other subjects.

Comprehensive Rehabilitation Centers

Ten awards were made to State vocational rehabilitation agencies in nine regions of the country and averaged $200,000 each. These State agencies have contracted with private nonprofit agencies to perform the basic functions of the centers. The main purpose of a center is to provide focal points in communications for the development and delivery of services to handicapped persons.

NATIONAL INSTITUTE OF HANDICAPPED RESEARCH

The Rehabilitation Act Amendments of 1978 removed the rehabilitation research program from RSA and placed it into a new organization, the National Institute of Handicapped Research (NIHR). The total appropriation for NIHR activities in fiscal year 1981 was $29,750,000.

Research Program

This research program is primarily directed toward discovering new knowledge and overcoming significant information gaps to the rehabilitation of severely disabled people. NIHR supports a broad spectrum of research projects including rehabilitation planning; reduction of attitudinal, legal and recreational barriers; post-employment services for severely mentally disabled clients; improving system that allow partially-sighted persons to read magnified print; research into the rehabilitation of end-stage renal disease patients; studying the effects of exercise on patients who have had a myocardial infraction, and spinal cord injury research.

Rehabilitation Research and Training Centers

There were 24 rehabilitation research and training centers functioning during fiscal year 1981 at a funded level of $15,704,000. Annually the centers conduct over 300 research activities and 659 training programs for over 41,818 trainees from 26 rehabilitation and health related disciplines. The mission of these centers is to improve rehabilitation methodology and service delivery systems through research and training. Special features of the centers include: Their affiliation with leading universities and service programs; they are geographically dispersed in 9 of the 10 HHS regions of the country; and each center has identified core areas of critical rehabilitation research which constitutes the focus of its research efforts. For example, core areas include cardiac rehabilitation, problems of spinal cord injury and its aftermath, muscle physiology in terms of maximizing the functions of impaired muscles, improvement of services, etc.

The center also accounted for 36.7 percent of the education and training resource materials used by rehabilitation educators annually. Over 25,500 publications and documents were distributed in fiscal year 1981. The informer, a quarterly periodical on center activities was distributed to recipients in over 40 countries.

Rehabilitation Engineering Centers

There were 15 rehabilitation engineering centers functioning in fiscal year 1981 at a funded level of $7,675,000. The purpose of the centers is the development of innovative methods of applying advances in medical, technological, psychological and social knowledge in the rehabilitation of disabled persons. The programs are designed to produce new scientific knowledge, equipment and devices suitable for solving problems encountered in the rehabilitation of handicapped people. Each of the centers has a working relationship with institutions of higher education in the fields of medicine, engineering, and related sciences. Strong intercenter coordination helps to avoid duplication of effort. Some of the latest rehabilitation engineering results include: A universal device for auditory tape indexing for the blind; a talking signs system for the blind; development of a controls evaluator and controls simulator for different situations which require control of rehabilitation engineering systems, such as a joystick for wheelchair control; a "spine table" to estimate the coordinates of points about the central mounting fixture, a wearable spectral tactile speech aid for the hearing impaired; and, development of a multichannel vibrotactile aid for evaluation in the deaf and deaf-blind.

ANCILLARY ACTIVITIES

Constituent Linkage

The Rehabilitation Act of 1973, as amended, the Mental Retardation Facilities and Community Health Centers Construction Act, as amended, and the Education for All Handicapped Children Act gave impetus to a changing role for the Federal Government in the area of linkage by providing funds for individual and group programs within the States and by mandating the involvement of disabled consumers in the policy development and consultation aspects of the development of the annual plan for rehabilitation services prepared by each State.

Interagency Liaison

Section 101(a)(11) of the act requires that VR agencies enter into cooperative arrangements with, and utilize the services and facilities of, other programs providing services related to rehabilitation, "* * * specifically including arrangements for the coordination of services to individuals eligible for service under this act; the Education of the Handicapped Act, and the Vocational Education Act * * *" Cooperative linkages and relationships between rehabilitation agencies and other public and voluntary agencies are critical to efficiency, economy and intergrated quality services for handicapped people.

Cooperative and collaborative agreements now exist with the Office of Education, Administration on Aging, Social Security Administration, Veterans Administration, Department of Labor, the National Institute of Mental Health, Special Education and others. A revised agreement was reached with the American Health Association which includes the provision of services to persons who have sustained strokes; also, a national workshop on improving linkages between mental health and vocational rehabilitation agencies and the signing of a cooperative agreement with the United Cerebral Palsy Foundation.

Services to Deaf Persons

In fiscal year 1981, an estimated 21,000 persons with communications disabilities were rehabilitated. Deaf people accounted for 7,600, while 11,000 were hard of hearing and 2,000 had speech or language impairments. In fiscal year 1981, almost all State VR agencies had a special coordinator to develop and supervise the State program for deaf and hearing impaired people. In addition, two special projects for deaf individuals served approximately 200. Over 1,000 severely handicapped deaf individuals have been rehabilitated since the inception of special projects in 1974.

Revised RSA-300 disability codes for hearing impaired became operative at the State vocational rehabilitation agencies. The revised codes which distinguish clearly between deafness and hard of hearing, aid rehabilitation counselors in planning appropriate services. Nine interpreter training programs were funded, including the training and growing availability of interpreters specializing in services to deaf-blind people and those with minimum language skills.

The International Year of Disabled Persons (IYDP)

The 31st regular session of the U.N. General Assembly adopted a resolution proclaiming calendar year 1981 as the International Year of Disabled Persons. Over 300 project and activities were implemented through existing budgets with no new appropriation.

National Council on the Handicapped

Established by the Rehabilitation Act of 1973, as amended by Public Law 95-602, the Council was created in response to a demand for a coordinated approach to Federal programs, policies and activities concerning disabled persons. The Council held an open public forum on the topic: The place of disabled persons in our economy. The forum included papers on job placement, job training, job site accessibility, employer incentives, apprenticeship opportunities, insurance, self-employment options, special problems of disabled minorities and disabled persons in institutions, career choices of disabled children and other economic factors.

Each of the six NCH meetings held during the year served essentially as a platform through members reviewing the status of programs and activities assisted or conducted by their agencies. Matters related to the Rehabilitation Services Administration and the National Institute of Handicapped Research have been on the agenda of every Council meeting.

Office of Information and Resources for the Handicapped (OIRH)

The clearing House on the Handicapped responded to 2,344 telephone inquiries, wrote 1,657 letters and distributed 66,526 publications. The Clearing House updated its "Pocket Guide to Federal Help for the Disabled Person," published the 1980 edition of "Resource Guide on Architectural Barriers Removal."

The OIRH also administers a training grant program that is designed to increase the number of skilled interpreters for deaf individuals. This activity was authorized in 1978 in the rehabilitation amendments and was begun in fiscal year 1980. Ten grant awards have been made to training programs throughout the country; these grants total approximately $900,000 and range from $85,000 to $98,000.

TITLE V—MISCELLANEOUS PROVISIONS OF THE REHABILITATION ACT

Employment

Section 501 of the Rehabilitation Act of 1973, as amended, requires that all agencies, departments, and instrumentalities of the executive branch of the Federal Government submit annual affirmative action program plans for the hiring, placement and advancement of handicapped individuals to the Office of Personnel Management (OPM), formerly the U.S. Civil Service Commission.

Two statistical studies were published: (1) "Statistical Profile of Handicapped Federal Civiliam Employees," and (2) the newly established "Governmentwide Disabled Women's Task Force." This latter publication analyzes the employment characteristics of severely disabled women as compared to severely disabled men, nonhandicapped women, and the general handicapped work force as of December 1980.

The "Handbook of Reasonable Accommodation" series was prepared and is tentatively scheduled for printing in fiscal year 1982. This handbook outlines procedures for conducting job analysis and/or worksite modification for disabled employees.

A 1-day showcase, titled "The Supervisor and the Disabled Person" was conducted in 1981. This was a joint OPM/Advisory Training Directors undertaking for the International Year of Disabled Persons which was attended by 150 Federal supervisors.

During fiscal year 1982, OPM reached an agreement with the Equal Employment Opportunity Commission to resume responsibility for the monitoring of agency affirmative action plans for disabled veterans, as required under Public Law 93-508 (Vietnam Era Veterans Readjustment Assistance Act of 1974).

Equal Employment Opportunity Commission (EEOC)

The Equal Employment Opportunity Commission (EEOC) has responsibility for enforcing nondiscrimination and affirmative action provisions of laws and regulations concerning Federal employment of handicapped individuals. The transition period that began in fiscal year 1980 was extended through fiscal year 1981.

Affirmative action program plans.—In response to specific instructions for submission of fiscal year 1981 6-month program plans, 82 agencies submitted complete plans; three submitted incomplete plans; and, 16 submitted no plans. *"Affirmative Action Accomplishment Reports"*—this report covers agency accomplishments during the period October 1, 1979, through September 30, 1981.

EEOC evaluated agency accomplishments during fiscal years 1980 and 1981 using criteria established to assess changes in the percent representation of persons with specified severe disabilities. In fiscal years 1980 and 1981, affirmative action program plans, agencies had established goals for achievement of specific increases in representation of persons with targeted disabilities. During the period October 1, 1979, through March 31, 1981, the accomplishments of 71 agencies were satisfactory and nine were unsatisfactory. Two agencies submitted incomplete reports, and 16 submitted no reports.

The number of handicapped individuals—that is, the combined total for persons with targeted disabilities and persons with other handicaps—and the number of disabled veterans employed decreased during the reporting period.

Architectural Barriers

Section 502 of the Rehabilitation Act of 1973, as amended, established the Architectural and Transportation Barriers Compliance Board (A&TBCB). The Board's program during most of fiscal year 1981 revolved around the Board's overwhelming concern with developing cost-effective minimum guidelines and requirements to be the basis of access standards. Several Board meetings were devoted to this rule and several notices were published.

The Board contracted with the National Conference of States on Building Codes and Standards in September 1980 to provide uniform interpretation and technical assistance on its guidelines and requirements for accessible design.

The 24-month, 50-State project, started in March 1981, began a critical dialog with the States, and continued into August 1981, reaching Federal, State, and local code officials in 22 States. Two States, Delaware and Nevada, have since adopted the Board's guidelines with minor modifications and several States, such as Tennessee and Kentucky, have or are considering incorporating portions of the guidelines into their State codes.

Employment Under Federal Contracts

Section 503 of the Rehabilitation Act of 1973, as amended, requires that any contract of excess of $2,500 entered into by a Federal department of agency for the procurement of personal property, and nonpersonal services for the United States shall contain a provision requiring affirmative action by the contractor to employ and advance in employment qualified handicapped individuals. Improvement in enforcement of equal employment opportunity and affirmative action has occurred during the first 2 years of the new consolidated office of Federal contract compliance programs.

During the fiscal year ending September 30, 1981, a total of just under 2,500 complaints of discrimination were received from handicapped individuals. These related on an almost equal basis to initial hire and termination. In this same period, some 2,386 cases were investigated, conciliated, and closed. During the year, the resolution of complaints with backpay as a remedy affected a total of 281 individuals and $1,095,574. The total far surpasses any single year since the inception of section 503 program.

Nondiscrimination Under Federal Grants

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination against qualified handicapped persons in all programs and activities conducted by recipients of Federal financial assistance. The Office for Civil Rights (OCR) has responsibility for enforcing section 504 in regard to programs and activities receiving funds from the Department of Education (ED). It also coordinated a department wide technical assistance program designed to encourage voluntary compliance with the regulations. OCR also works with various program agencies within HHS to integrate section 504 nondiscrimination requirements into program audits and program administration.

Based on a preliminary analysis of regional reports, OCR received 706 individual complaints alleging discrimination under section 504 during fiscal year 1981. This compares with 937 complaints received in fiscal year 1980.

During fiscal year 1981, OCR completed action of 679 discrimination complaints that raised section 504 issues. The most important issues raised in the complaints covered the general categories of employment (recruitment, selection, and testing; demotions and dismissals) and services (exclusion of beneficiaries from programs or facilities, physical accessibility, and comparability of programs and services).

During fiscal year 1981, OCR initiated 65 compliance reviews of hospitals and State health or human services agencies that involved section 504 issues. An additional 146 reviews are carried over from fiscal year 1979 and fiscal year 1980. During fiscal year 1981, OCR completed 24 reviews covering section 504 issues.

The issues most commonly addressed in the fiscal year 1981 compliance reviews were: (1) Admission policies and practices; (2) accessibility/availability of services; (3) differential treatment within programs; (4) program planning and administration; (5) employment; and (6) procedural violations.

Nondiscrimination Under Federal Grants and Programs (Department of Justice)

Executive Order 12250 continued in effect the guidelines for enforcement of section 504 issued by the Department of Health, Education, and Welfare in 1978 and transferred them to the Department of Justice.

In fiscal year 1981, Coordination Regulations Section (CRS) reviewed six agency regulations and approved them for publication in the Federal Register, and reviewed and commented on 10 other regulations concerning section 504 which are still under revision. CRS also assisted the Office of Revenue Sharing, and the Department of Health and Human Services (HHS), in the development of training course entitled "Discrimination of the Basis of Handcap." In addition, CRS has collected and is reviewing training materials on seciton 504 that has been developed or contracted for by HHS and the Department of Education (ED) under Executive Order 11914.

Nondiscrimination Under Federal Grants and Programs (Department of Education) tion)

During fiscal year 1981, OCR received 1,435 complaints alleging discrimination on the basis of handicap. Of these complaints, 67 percent involved elementary and secondary institutions 25 percent postsecondary/vocational rehabilitation institutions and 8 percent of education-related institutions. Furthermore, there were 1,571 section 504 complaint closures and over 60 section 504 compliance reviews.

More than 5,000 persons received training through OCR contractor workshops. In addition, an estimated 12,500 persons were provided training and technical assistance information indirectly, through followup efforts of approximately 50 percent of those initially trained. Technical assistance informational materials disseminated by contractors reached about 225,000 recipients beneficiary orgainzations and others. Regional Technical Assistance (RTAS) collectively responded to 14,799 requests for technicial assistance from identified target populations utilizing a variety of delivery methods.

There were nine new section 504 projects totaling $3,227,795. OCR published two "Digests of Significant Case-Related Memoranda" summarizing significant policy decisions. OCR reviewed section 504 regulations. Methods of administration relative to section 504 were also received and approved from all 50 States and insular possessions with the exception of two.

Interagency Coordinating Council

The 1978 amendments to the Rehabilitation Act added a new section 507, to title V. The purpose of section 507 is to maximize effort, promote efficiency and eliminate conflict, competition, and duplication among the various departments and agencies of the Federal Government responsible for implementing title V.

Some of the Council's activities during the last fiscal year were: (1) Agreed to procedured by which the Equal Employment Opportunity Commission review employment provisions of proposed agency rules prior to review by the Department of Justice of final agency submissions; (2) recommended to the Census Bureau and the Secretary of Commerce that a post census disability survey be conducted; (3) agreed to recommend that the Fair Labor Standards Act be amended to permit the integration of sheltered worshop and work activity center clients; and, (4) encouraged the revision of minimum guidelines by the Architectural and Transportion Barriers Compliance Board to be more consistent with the ANSI standard.

ITEM 5. DEPARTMENT OF ENERGY

JANUARY 24, 1983.

DEAR MR. CHAIRMAN: In response to your letter requesting an update of the Department's activities in 1982 affecting older Americans, I am submitting the following enclosures that describe: (1) Departmental activities in areas of energy efficiency programs, information collection and distribution, and public participation; (2) research on the biological and physiological aging process.

I am pleased to contribute to the annual report of Federal activities and programs relating to older Americans.

Sincerely,

DONALD PAUL HODEL, *Secretary.*

Enclosures.

ENERGY EFFICIENCY PROGRAMS, INFORMATION COLLECTION AND DISTRIBUTION, AND PUBLIC PARTICIPATION

An overview of the Department of Energy's (DOE) efforts should be considered before a detailed presentation of activity in each of the following areas: Energy efficiency programs, information collection and distribution, and public participation. DOE's immediate and long-term objectives are the assurance of adequate, available, safe and realistically priced energy supplies for all American consumers. These objectives have been pursued within the guidelines of a balanced national energy policy that includes a variety of energy sources. These objectives also recognize the need to be aware of and sensitive to the impact of the cost and availability of energy on moderate and low-income older American households.

During 1982, DOE has remained aware of the need to address policy and price impact issues on older consumers and has continued to be involved with national organizations and Federal agencies who are concerned with the energy needs of older Americans. Those activities will be described in more detail below. The following will be a description of activities and programs in the aforementioned areas.

ENERGY EFFICIENCY PROGRAMS

Weatherization assistance program.—The low-income elderly and the handicapped receive priority under this program which provides grants for the installation of insulation, weatherstripping, storm windows, and other energy-saving measures.

In 1982, the weatherization assistance program awarded over $149,848,000 in grants to the States and 25 Native American tribal organizations for the weatherization of homes of low-income people. Reports submitted from the inception of the program through October 1982, indicate 905,739 low-income homes were weatherized and that most of those dwellings were occupied by the elderly. In 1982, 155,028 homes were weatherized.

Residential conservation service.—Implementation of this program by the States began in October 1981. The program reqires major utilities to offer energy audits, to offer to arrange for the financing and installation of energy conservation measures and to permit repayment of associated loans through monthly utility billings. The program also requires development of lists of suppliers, contractors and lenders. This program should be useful to the elderly as well as other members of the population. Revised regulations, aimed at reducing associated burdens, were published in the Federal Register on June 25, 1982.

Institutional conservation program.—Title III of the National Energy Conservation Policy Act provided for a matching grant program to support, among other things, professional analyses of the energy conservation potential in public care facilities. The effort of this program is to identify for building operators ways to conserve energy and thus cut their operating costs. The program also hopes to influence the capital investment decisions of the institution's management.

The energy efficiency programs described above have been under a budget review process which may result in future budget authority and funding from other appropriate sources.

INFORMATION COLLECTION AND DISTRIBUTION

The Energy Information Administration collects and publishes comprehensive data on energy consumption in the residential sector through the residential energy consumption survey. This survey includes data collected from individual households throughout the country and actual billing data from the households' fuel suppliers for a 12-month period. The data includes information on energy consumption, expenditures for energy, cost by fuel type, and related housing unit characteristics (such as size, insulation, and major energy-consuming appliances).

In 1982, the Energy Information Administration published two major reports from this survey that contain data about the elderly. The report, "Residential Energy Consumption Survey: Housing Characteristics, 1980," provides data on energy-related characteristics, including the square footage of floor space and the use of fuels. Estimates of the cost and quantities used of electricity, natural gas, fuel oil, kerosene and liquified petroleum gas for elderly households are reported in the "Residential Energy Consumption Survey: Consumption and Expenditures, April 1980 through March 1981." Three volumes of this report are planned. Part 1 has been published and contains national data. Slated for publication in 1983, part 2 will contain data for the nine Census divisions and part 3 will contain separate tables of energy consumption and expenditures for elderly households. The published reports can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20401.

PUBLIC PARTICIPATION ACTIVITIES

DOE continued its active participation in the "Energy and Elderly Consortium." The consortium is composed of over 60 organizations from the public sector, private nonprofit sector, and from the energy industry. This organization is the only one of its kind that brings Federal agencies such as DOE and the Administration on Aging together with national aging organizations, and the private industry sector such as the American Gas Association, American Petroleum Institute, Edison Electric Institute, and others, to review and discuss solutions for the energy-related needs of the elderly.

The Office of Consumer Affairs of the Office of the Assistant Secretary for Congressional, Intergovernmental and Public Affairs has represented the Department with this organization serving as a member of the Steering Committee and Technical Assistance Committee. Through participation in this group, DOE has exercised leadership in forming partnerships with a variety of organizations that have worked to meet the energy needs of the elderly.

This participation produced two conferences during the course of 1982. These conferences were conducted with the White House Office of Consumer Affairs as cosponsor. The theme and title of these events were meeting the needs of the elderly through "Building Partnerships" with private voluntary, private for-profit energy industries, and government agencies responsible for serving older constituents. The first conference was conducted in the Washington, D.C. area in February, and the second was in Seattle, Wash., in June.

The Office of Consumer Affairs has worked together with the Center for Environmental Physiology, the Administration on Aging, ACTION, the Department of Health and Human Services, and the White House Office of Consumer Affairs to develop, print and distribute public information concerning weather related health risks (hypothermia and hyperthermia) for the elderly. This collaborative effort helped facilitate the first circulation of a publication concerning the importance of preventing critical health risks for the elderly when weather conditions become cold in winter and very hot in the summer.

DOE's staff has maintained open channels of communication with six Federal agencies and Departments for the purpose of improving information exchange about energy assistance programs. This information exchange gives particular attention to any provisions in the programs that allow for special attention to the elderly.

DOE has distributed notices to organizations representing the elderly of proposed procedures and public hearings concerned with overcharge settlements with oil and gas companies.

The Office of Equal Opportunity has submitted for the approval of the Secretary, Health and Human Services, proposed regulations on nondiscrimination on the basis of age applicable to Federal grant funded programs. The purpose of the proposed regulations is to implement the provisions of the Age Discrimination Act of 1975, as amended, which prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. In addition, DOE personnel policies governing such activities as recruitment, training, employee relations, labor management, and performance appraisal prohibit discrimination on the basis of age.

The present Administration's philosophy is clearly presented in the current national energy policy plan, "Serving America's Energy Future." This national energy plan states in the first chapter the role of the Federal Government and presents the basic principles and guidelines for our energy future. It is as follows: "The Federal Government has one overriding concern in energy during the years ahead. That is to establish sound, stable public policies that will encourage individuals and groups in the private and public sector to produce and use enegy resources wisely and efficiently."

"The best guarantee of maintaining a wholesome balance among competing interests in regard to energy lies in allowing the American people themselves to make free and fully informed choices."

"All Americans are involved in making energy policy. When individual choices are made with a maximum of personal understanding and a minimum of governmental retraints, the result is the most appropriate energy policy."

RESEARCH RELATED TO BIOLOGICAL AGING

As in previous years the Office of Health and Environmental Research (OHER) has administered a major program of research aimed at identifying and characterizing the health impacts of energy. In assessing the energy-related health impacts, it is important to identify and characterize long-term, late-appearing effects induced by chronic exposure to low levels of hazardous chemical and physical agents. Health effects caused by chronic low-level exposure to energy-related toxic agents often develop over the entire lifespan. Consequently, such effects must be clearly distinguished from the normal aging process. To make a valid distinction between chemical toxicity and spontaneously occurring changes, information on pathophysilogical changes occurring throughout the lifespan must be collected for both experimental and control (unexposed) groups. These data are obtained primarily from controlled studies in animals and help to characterize the normal aging processes as well as the toxicity of energy-related agents over time. Additional studies are conducted to obtain a better understanding of the aging process itself. Thus, although DOE does not sponsor a specific program of research on aging, two categories of studies related to biological aging were pursued during 1982: (a) Studies indirectly concerned with biological changes occurring over long periods of time in animals and in humans; and (b) studies designed to elucidate the biological processes in aging.

As in the past, lifetime studies of humans and animals constitute the major effort in ongoing research related to biological aging. Because of a long-term involvement in lifetime animal studies, several DOE laboratories contribute information to the Laboratory Animal Data Bank developed by the Battelle Columbus Laboratories under support from the National Library of Medicine and other Federal agencies. DOE laboratories provide data on life histories, pathology, hematology, and clinical chemistry from control animals throughout their lifespan.

As in previous years, research directly concerned with the aging process has been conducted on a limited scale at several of the Department's contractor facilities. Summarized below are specific research projects addressing aging that the Department sponsored in 1982.

LONG-TERM STUDIES OF HUMAN POPULATION

These studies provide valuable data on health effects and life shortening in human populations exposed to hazardous chemical and physical agents associated with the energy technologies. Additional information on lifespan and aging in human populations is also collected. Since long-term studies of human populations are costly, time-consuming, and complex, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), sponsored jointly by the United States and Japan, continued work on a lifetime followup of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study.

Detailed clinical and laboratory studies, and morality and autopsy data are collected on irradiated and control populations to identify diseases that have contributed to life shortening among survivors. An important feature is the acquisition of valuable quantitative data on dose-response relationships. Studies specifically concerned with age-related changes are also conducted. It was recently reported that the effects of ionizing radiation on mortality are specific and focal, and principally carcinogenic. No evidence of radiation-induced premature aging has been obtained.

After being accidentally exposed in 1954 to radioactive fallout released during the atmospheric testing of a thermonuclear device, a group of some 200 inhabitants of the Marshall Islands has been followed clinically, along with unexposed controls, by medical specialists at the Brookhaven National laboratory. Thyroid pathology, which has responsed well to medical treatment, has been prevalent in individuals heavily exposed to radioiodine. (This study is currently conducted under the auspices of the Department's Office of Operational Safety.)

Nearly 2,000 persons exposed to radium, occupationally or for medical reasons, have been studied at the Center for Human Radiobiology, Argonne National Laboratory. Individuals in the study receive medical and radiologic (dosimetric) examinations at the center. Work emphasizes the study of persons with relatively low-body burdens of radium. Data on tumor induction by bone-seeking, alpha-emitting radionuclides are being generated. Of importance are quantitative dose-response data for tumorigenesis.

At the Los Alamos National Laboratory, an epidemiologic study of plutonium workers at six Department of Energy facilities is in progress. An estimated 15,000 to 20,000 workers will be followed in the study of mortality data and at least one-third of these will also be studied by collecting detailed morbidity and personal-history data periodically via questionnaires. Autopsy data are obtained through the U.S. Uranium/Transuranium Registry (see below). So far there is no excess mortality due to any cause in 224 males with the highest plutonium exposures: A higher than normal incidence of digestive tract cancers in both males and females is likely due to cultural and socio-economic factors; and 26 males exposed to plutonium during World War II show no evidence yet that adverse effects exist nearly 40 years after exposure.

Some 600,000 contractor employees at Department of Energy facilities are being analyzed in an epidemiologic study to assess health effects produced by long-term exposure to low-levels of ionizing radiation. Workers at the Hanford (Washington) and Oak Ridge (Tennessee) plants, at the Mound Laboratory (Miamisburg, Ohio), and other facilities are subjects of the study, which is directed by Oak Ridge Associated Universities (ORAU) with assistance from teams at each of the facilities that house the workers' records and vital statistics. Radiation dosimetry as well as exposures to other toxic agents in the work environment are carefully evaluated.

The U.S. Uranium/Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, collects occupational data (work, medical, and radiation exposure histories) as well as information on mortality in worker populations exposed to plutonium or other transuranium radioelements. Detailed autopsy data are obtained on workers at the time of death. At the present time, some 14,500 workers from 10 facilities are registered with the foundation. The autopsy data are available for use in other epidemiologic studies such as the ORAU study of radiation workers and the Los Alamos study of plutonium workers. A similar registry of uranium workers was started in 1979.

A study to determine possible relationships between the work environment and worker health is being conducted on 400,000 workers employed at eight shipyards since the early 1950's. Approximately 125,000 of these workers have had exposure to external radiation. The purpose is to identify past and present shipyard employees and to establish an automated record system that incorporates data on individual work histories, types of jobs, radiation exposures, estimated exposures to other workplace hazards, and smoking and drinking histories. It is planned to establish the vital status of all workers and cause of death among deceased workers, and to conduct analyses to establish a dose-response relationship between radiation and mortality by cause of death. At this time, employee records at all eight shipyards have been microfilmed and basic data are being abstracted and transferred to magnetic tape.

LIFETIME STUDIES IN SHORT-LIVED MAMMALS

Although data from humans are indispensable in the assessment of health impacts associated with any hazardous agent, limitations inherent in human studies make it mandatory to acquire quantitative data from controlled lifetime studies of animal populations. Data from animals significantly enhance predictive capabilities. Data from both short-lived and long-lived mammals are needed.

Small rodents with lifespans of 2 to 3 years (rats, mice, hamsters) provide data in a minimum of time and at low cost. Consequently, rodents have been used in large-scale studies of late somatic and genetic effects induced by low doses of ionizing radiation. For example, at the Argonne National Laboratory and the Oak Ridge National Laboratory, mice have been exposed to ionizing radiation delivered in different daily increments to characterize radiation-induced diseases and abnormalities that reduce the lifespan. These studies using gamma and neutron radiations have yielded valuable information on dose rate and radiation quality as important factors that modify mammalian response to radiation stress. The study of control (unexposed) populations is providing data on lifespan, morbidity patterns, and causes of death in unstressed animals. Lifetime studies of tumorigenesis and other somatic effects of ionizing radiation in rodent populations are currently being conducted at the Brookhaven National Laboratory, the Lawrence Berkeley Laboratory, the Batteile-Pacific Northwest Laboratory, the Oak Ridge National Laboratory, the University of Utah, the Lovelace Inhalation Toxicology Research Institute, and the University of California, Davis. Included in the ongoing effort are studies involving external sources, neutrons, gamma radiation, and heavy ionizing particles, actinide isotopes that are present in nuclear fuels (plutonim-239, american-241, uranium-233, and others), radium isotopes, and products of nuclear fission (including tritium and krypton-85).

At the Lovelace Inhalation Toxicology Research Institute, lifetime studies of rodents exposed to emissions from fludized-bed combustion facilities are in progress. Biological end-points being assessed are lifespan shortening, functional disorders, and pathological changes, including carcinogenesis. Two projects at the Pacific Northewest Laboratories are evaluating the chronic toxicity of metals and metal oxides in emissions and effluents from coal combustion facilities. In these studies, rodents are exposed by ingestion and by inhalation. Emphasis is placed on evaluating iron-deficient and newborn animals as subpopulations sensitive to toxic effects of cadmium.

In related work currently in progress at the Lovelace Inhalation Toxicology Research Institute, carcinogenic, mutagenic and other adverse effects of particulate exhaust emissions from diesel automotive engines are under investigation. The purpose of this study is to evaluate chronic health effects that may be associated with the large-scale use of light-duty diesel vehicles. Included in the ongoing effort is a study of chronic health effects in rodents chronically exposed to diluted diesel-engine exhaust emissions throughout the entire lifespan. A total of 1,800 mice and nearly 1,900 rats are involved in the lifetime study.

A number of lifetime studies are conducted in connection with the conversion of coal to secondary fuels and the extraction of oil from oil shale. Studies are underway to assess the cancer incidence and lifespan reduction caused by exposure to polynuclear aromatic hydrocarbons from coal gasification and liquefaction. Argonne National Laboratory conducts a program on the role of cancer-promoting agents in malignant tumor production in skin, lung, and liver. At the Oak Ridge National Laboratory, lifetime animal studies are comparing skin, lung, and nonspecific cancer caused by compounds in coal liquefaction products. A related project has begun to assess the chronic toxicity of various classes of chemicals in products from coal liquefaction operations. Lifetime studies in rats and hamsters at the University of Connecticut, Farmington, are defining chronic toxicity and carcinogenic risks associated with the ingestion and inhalation of nickel-containing materials in the waste streams of coal gasification facilities. At the Los Alamos National Laboratory, ongoing research with rodents is assessing chronic pulmonary toxicity of raw and spent oil shale, evaluating the pulmonary carcinogenicity of crude shale-oil fractions, and defining health effects associated with chronic exposure to retort gases and particulates.

LIFETIME STUDIES WITH LONG-LIVED MAMMALS

From some points of view, long-lived mammalian species represent better human surrogates than do their short-lived counterparts. Thus, obtaining quantitative data on responses of long-lived species to hazardous agents is important. The beagle dog has served for more than 20 years as the long-lived mammal in lifetime radiation-effects studies sponsored by the Department of Energy. Data from beagles facilitate attempts to interrelate data on animal responses with those on humans. At the Argonne National Laboratory, the University of Utah, the University of California, Davis, the Lovelace Inhalation Toxicology Research Institute, and the Pacific Northwest Laboratories, populations of beagles are kept under careful experimental observation. In these lifetime studies, periodic clinical examinations and laboratory analyses are performed on all exposed and control animals, and complete data on gross pathology and histopathology are collected. Accumulated data contain a wealth of information on lifespan, age-related changes, morbidity, mortality, and causes of death in normal animals, as well as alterations in these characteristics that may be induced by radiation. Lifetime studies currently in progress focus primarily on late appearing radiation effects. Included are studies of external radiation (gamma radiation) and internally deposited radionuclides administered by inhalation, ingestion, or injection. All ongoing studies involve careful dosimetric measurements and the acquisition of dose-response data. Because of cost and time, lifetime studies of beagles are initiated on a highly selective basis. No energy-related agent other than ionizing radiation has yet been evaluated via a lifetime study in a long-lived animal. Limited studies of other agents may be undertaken in the future as needs for such studies are identified by short-term testing in other biological systems.

RESEARCH DIRECTLY CONCERNED WITH AGING

Interest in biological aging has continued at the Oak Ridge National Laboratory where progress was made in several areas of research related to the aging process. A study of possible age-related changes in transfer-RNA molecules has been completed. Contrary to preliminary observations, the weight of evidence now suggests that no consistent age-related changes are detectable using available techniques. This project, which is supported in part by a training grant from the National Institutes of Health, is now directed to the study of albumin molecules and has progressed to the state where it is possible to compare the fidelity of albumin molecules produced by young and by old mice with assurance that results will be free of artifactual heterogeneity.

Albumin is analyzed by a specific antibody reaction, by isoelectric focusing, and by SDS gel electrophoresis. No evidence of age-related changes in the albumin molecule has yet been detected. In another study, Oak Ridge investigators have been conducting experiments with two strains of mice differing significantly with respect to length of lifespan—one has a mean lifespan of over 700 days as opposed to a mean lifespan of only about 450 days in the other—in order to investigate genetic factors underlying aging and longevity. A major difference between the two strains has been found to reside within a cluster of genes known as the major histo-compatibility complex (MHC), which is known to regulate functions of the immune system. It is also known that length of lifespan is significantly affected by genetic factors and that aging is associated with marked changes in the MHC. Results of the Oak Ridge study suggest that genes controlling the MHC may also control the aging process. In a third study at Oak Ridge, tumorigenic responses to diethylnitrosamine (DEN) were investigated in mice of different ages. When compared with young animals, the aging mice were found to have similar incidences and types of tumors of the same size and in the same tissues. In the aging of animals, however, tumors developed after shorter periods of exposure to DEN. It is concluded that age at the time of exposure does not alter the tumor-susceptible tissue or types of tumors induced by DEN treatment, that tumor incidences are not affected by age at time of exposure, and that mice die earlier from induced tumors as age at time of exposure increases.

At the Brookhaven National Laboratory, the relationship between two aging constants—the Gompertz function and the maximum potential lifespan (T)—has been examined for 25 animal species exhibiting considerable difference in patterns of growth. For these species, the product of the two constants (t) was found to be roughly the same (less than an order-of-magnitude overall variation). This finding is interpreted as evidence against the somatic mutation theory of aging and in favor of the view that aging is related to metabolic factors (such as free radical production during respiration). Also at Brookhaven, further research was conducted to explore the possibility that the aging process is affected by cellular capacity for DNA repair. For this purpose experiments were carried out using four types of cell systems: (1) Cells from individuals with premature aging syndromes; (2) cells from old and young animals of the same species; (3) cells of different ages in culture; and (4) cells of the same age but from species with different lifespans. Based on data obtained, there seems to be no causal connection between aging and a decrease in DNA repair. The experiments are "best described as indicating that cells lose the capacity to do effective DNA repair as they age just as they lose the capacity to do many other things."

Research at the Chemical Biodynamics Division, Lawrence Berkeley Laboratory, has explored behavioral responses (shock-motivated passive avoidance task) in young, intermediate-age and old mice to the protein synthesis inhibitor, anisomycin (ANI). Observations made indicate that the retention of older mice is susceptible to disruption by the action of ANI for a longer time after training than normally occurs in young or intermediate age mice. The preliminary interpretation of this finding is that the transition time from short-term to long-term memory is longer in older mice than in young mice.

TRENDS AND PROSPECTS

Given the need to assess long-term and late-appearing effects of hazardous agents associated with energy technologies, lifetime studies of animal and human populations will continue. Additional lifetime studies of chemical agents will be needed in the future. Accordingly, more data describing age-related changes should be forthcoming.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

National Long-Term Care Channeling Demonstration Program

The U.S. Department of Health and Human Services (DHHS), in recognition of the large and rapidly growing need for long-term care for the functionally impaired elderly, has funded a major demonstration to test the feasibility and cost-effectiveness of an alternative community-based long-term care service delivery concept integrating health and social services. Ten community projects in ten different States are now implementing the national long-term care channeling program. Participating States are Florida, Kentucky, Maine, Maryland, Massachuetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

The channeling program is directed at providing community-based long-term care services to people 65 and older who are functionally impaired and are unable to manage the essential activities of daily living on their own, and who lack adequate informal supports. The core purposes of the channeling program are:

(1) To marshal and direct long-term care resources in a community in ways that contain overall costs.

(2) To increase access to a wider range of serivces than is currently available.

(3) To match services used to the identified needs of the client.

(4) To concentrate public resources on those persons with the greatest need for subsidized long-term care.

(5) To stimulate the development of needed in home and community services which do not exist or are in short supply.

(6) To reduce the unnecessary use of publicly-subsidized long-term care services, including costly medical and institutional services.

(7) To promote efficiency and quality in community long-term care delivery systems.

(8) To promote a reasonable division of labor between informal support systems (including families, neighbors, and friends), privately financed services and publicly-financed care; and

(9) To maintain or enhance client outcomes, including physical and mental functioning and quality of life.

There are two variants of channeling that will be tested in the demonstration: A basic case management model and a financial control model (or complex model).

The basic case management model superimposes a coordinating and accountability mechanism—case management—onto the present system of services and client eligibilities. It accepts the features of the present long-term care system as given and introduces a mechanism responsible for helping clients gain access to and coordinate the services they need to continue to live in the community. The channeling organization assigns to each client a case mangager, who performs a comprehensive assessment of service needs; develops a plan of care that responds to those needs; arranges for the provision of needed services, relying on family and friends where feasible; follows up to see that they are provided and monitors their provision on an ongoing basis; and reassesses needs periodically or when cirumstrances change. Thus, the case manager is accountable for identifying the entire package of services needed by the client and serves as a client advocate in negotiating the complex array of programs and service providers.

The basic case management model, therefore, tests the premise that the major difficulties in the current long-term care system are problems of information, access, and coordination, which can be essentially solved by client-centered case management.

The financial control model (or complex model) modifies the basic model to directly address issues of cost control and to strengthen the projects ability to access needed services. It modifies several key features of the current long-term care system by introducing a fixed budget, a wider range of services, increased project authority over expenditures, and expanded eligibility to reach those in need. The fixed budget, set at 60 percent of the average medicaid skilled nursing facility-intermediate care facility (SNF/ICF) rate in the catchment area, is designed to help gain control over rising costs and increased demand for long-term care services. In order to make a variety of services available that are less costly and offer clients and care planners the opportunity to choose a more appropriate and efficient care plan, waivers are provided to expand community service options.

Services for which coverage is extended include: Day health and rehabilitative care, day maintenance care, home health aid services, homemaker/personal care services, housekeeping services, chore services, companion service, home-delivered meals, respite care, skilled nursing, physical therapy, speech therapy, occupational therapy, mental health services, housing assistance, adult foster care, nonroutine consumable medical supplies, and adoptive and assistive equipment.

These services are paid for from a pool of service dollars. This pool is comprised principally of medicare and medicaid funds through waivers of requirements of those programs. From the prespective of client and case managers, services reimbursed out of the services pool are not dependent on a client's eligibility for particular categorial programs. Case managers have the power to authorize the amount, duration, and scope of services paid for from the funding pool. This vests in the case manager the power to limit, alter, or terminate services in response to changes in client needs. The power to authorize community-based services irrespective of funding source enhances the case manager's ability to obtain services for clients and makes the case manager accountable for the full package of services funded.

The design and planning phase of the projects has been completed. The basic case management model is being tested in five sites, all which began operation in February and March of 1982, except one site which began in June. The basic model sites are located in Kentucky, Maine, Maryland, New Jersey, and Texas. The five additional sites where the financial control model is being tested were implemented in May and June of 1982. These sites are located in Florida, Massachusetts, New York, Ohio, and Pennsylvania.

A uniform evaluation of all ten sites using a randomized experimental design is being conducted during this 4-year demonstration program. The evaluation is using common data collection instruments and procedures across all sites to answer the following questions:

—Does channeling enable clients to live in less restrictive settings by substituting community-based care for institutional care?

—Does channeling maintain reliance on informal supports and reduce the psychological and financial burden of care placed on families and other informal caregivers?

—What is channeling's impact on the public and private costs of long-term care?

—Does channeling improve the quality of life (both objective and subjective) and lower mortality for its clients?

—Is channeling a cost effective long-term care intervention?

—Do the answers to the above questions differ among subgroups of the target population and across variants of the channeling model?

All demonstration sites are scheduled to run for three years and the final research report is scheduled for completion in 1985.

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING

REPORT FOR FISCAL YEAR 1982

INTRODUCTION

This report describes the major activities of the Administration on Aging (AoA) in fiscal year 1982. Title II of the Older Americans Act of 1965 (the act) established the Administration on Aging as the principal Federal agency for carrying out the provisions of the act. The provisions of the Older Americans Act are essentially concerned with removing barriers to economic and personnel independence for older persons and with assuring the availability of appropriate services for those older persons in the greatest social or economic need. These provisions are implemented primarily through the establishment of a national "network on aging." This network consists principally of the Administration on Aging at the Federal level, the State agencies and area agencies on aging established under title III of the act, and the agencies and organizations providing direct services at the community level. In fiscal year 1982, Congress appropriated a total of $636,272,000 to support programs and activities to implement the provisions of the Older Americans Act, as amended. (See appendix I for a summary of AoA's budget for fiscal year 1982.)

This report is divided into four sections. Section I describes the functions, responsibilities, and interagency activities of the Administration on Aging. Section II provides an overview of the provisions of title III of the Older Americans Act, and summarizes the principal activities of the network of State and area agencies on aging in fiscal year 1982. Section III describes the title IV program of grants to Indian tribal organizations. Section VI program of grants to Indian tribal organizations. Section IV presents a summary of AoA's fiscal year 1982 discretionary activities under title IV, a description of the evaluation projects carried out under title II of the Act, and a description of the fiscal year 1982 activities concerned under AoA's long-term care program.

SECTION I. THE ADMINISTRATION ON AGING

ROLE AND FUNCTION OF AOA

The Administration on Aging is located within the Office of Human Development Services in the Department of Health and Human Services (DHHS). It consists of a central office, staffed by 112 permanent, full-time employees, in Washington, D.C., and 10 regional offices, staffed by 130 permanent, full-time employees. Title II of the Older Americans Act, as amended, describes the basic roles and functions of AoA. Chief among these are to administer the programs authorized by Congress under titles III, IV and VI of the act, and to serve as an effective and visible advocate for older persons within the Department and with other agencies and organizations.

The AoA regional offices are responsible for providing direction and guidance to the State agencies on aging funded under title III, and assistance to Governors and other State officials in the planning and implementation of policies and programs for older persons. They are responsible for approving title III State plans, as well as for overseeing the collection of performance data used in analyzing the effectiveness of the title III program. Regional offices also administer selected discretionary grants, including some model projects and training grants authorized under title IV.

In addition to its responsibilities for administering titles III, IV, and VI of the act, the Administration on Aging plays an active role within the Federal Government on behalf of the aging network and the older population in a variety of ways. AoA provides advice, assistance, and consultation to the Assistant Secretary for Human Development Services, the Secretary of the Department of Health and Human Services, other Federal agencies, and to Congress, on the characteristics, circumstances, and needs of older persons. It also reviews and comments on departmental policies and regulations concerning services which affect the health and general well-being of older persons.

A major effort by the Administration on Aging at the Federal level has been the development and implementation of cooperative arrangements with other Federal agencies and private organizations to foster the coordination of Federal programs related to the purposes of the Older Americans Act. AoA has entered into numerous formal interagency agreements to achieve this purpose. Examples of these agreements are described below.

U.S. Department of Agriculture/Farmers Home Administration.—AoA has an agreement with the Farmers Home Administration (FmHA) to increase the availability of congregate housing and services to rural older persons. This agreement was initiated in fiscal year 1979, and continued through fiscal year 1982. FmHA agreed to support construction of congregate housing facilities at 10 demonstration sites and AoA agreed to assist in financing the provision of supportive services. In fiscal year 1982, AoA continued funding support for the provision of supportive services at these sites. Also in fiscal year 1982, a publication entitled "Housing Older Persons in Rural America: A Handbook on Congregate Housing" was developed and distributed to the national network on aging.

Office for Civil Rights/DHHS.—In fiscal year 1981, AoA initiated a formal agreement with the Office for Civil Rights (OCR) to provide technical assistance to State agencies and aging to promote voluntary compliance with the Age Discrimination

Act regulations by programs and activities funded by the Department of Health and Human Services. Currently a contractor jointly supported by OCR and AoA is providing technical assistance to State agencies.

Department of Housing and Urban Development (HUD).—Since 1980, AoA and HUD have supported a contract for an evaluation of the congregate housing program. The evaluation examines the financial requirements and implications of congregate housing as well as service delivery strategies. This evaluation is scheduled for completion in December 1983. In addition, AoA and HUD are working together to develop a synthesis of recent research and evaluation studies relating to housing that have been undertaken by each agency.

Veterans Administration (VA).—AoA established an agreement with the VA in fiscal year 1981, to analyze and assess the VA hospital-based home care program. This agreement will result in information regarding the costs of providing professional services in the home, relate the outcomes of different treatment methods to the costs of those treatments, and determine the type of staff needed to provide such services in a cost-effective way.

ACTION.—AoA is assisting the older American volunteer program in the development of two "how to" guides on transportation and nutrition services for their foster grandparent and retired senior volunteer programs, and other grantees. One booklet is in the process of being printed, and work has begun on the second one.

Department of Education.—An agreement was signed in fiscal year 1982, with the Office of Vocational and Adult Education, to develop and expand educational opportunities for older persons. Among other things, the agreement is intended to promote improved linkages between State and area agencies on aging and the network of educational institutions providing adult education and to promote improved access by older persons to educational opportunities.

Administration for Native Americans.—This agreement initiates a special project on four Indian reservations and in one urban center to increase the number of older Indians receiving cash and other benefits from entitlement programs.

ACTION and the American Gas Association.—An agreement was signed to produce a factsheet on how to avoid heat stress. Approximately 500,000 copies were distributed by AoA and ACTION to the aging network and to the Retired Senior Volunteer Corps nationwide during the summer of 1982.

Center for Environmental Physiology, White House Office of Consumer Affairs, ACTION, the HHS Office of the Assistant Secretary for Planning and Evaluation, and the HHS Office of Health Promotion and Disease Prevention.—During the winter of 1981-82, AoA joined with the above-named agencies in producing a factsheet for older persons on hypothermia awareness, identification, and emergency treatment. Also a series of background papers on hypothermia and its effect on older persons were produced for professionals in the field of aging. These documents were distributed to the network on aging, along with information about the use of a special low-reading thermometer which can be used to detect hypothermia.

Intra-Departmental Council on Indian Affairs, Administration on Developmental Disabilities, and the Administration for Native Americans.—An agreement was signed in 1982 to improve coordination of program efforts that enhance or extend services to more individuals without an increase in cost to individual agencies, and to effect measurable, positive impact on income security, health care, and access to services for Indian older persons.

Administration for Children, Youth, and Families (ACYF).—AoA and ACYF have jointly funded a project to the University of Southern California which undertakes activities to promote closer linkages between children and older persons, and studies mutually beneficial reciprocating roles with emphasis on the involvement of older persons as volunteers in preschool programs. As an outcome of this project, AoA expects that two documents will be produced for dissemination. The first is a technical assistance manual on successfully integrating elderly services in preschool programs. The second is a research report that will include a series of case studies on the kinds of useful interactions that can exist between children's programs and older persons' programs.

In addition to the leadership and advocacy activities carried out via interagency agreements, AoA has also pursued many other leadership and advocacy activities during fiscal year 1982. Examples are listed below:

—AoA developed a document that is a comprehensive action plan setting forth AoA's policies, goals, objectives, and priorities for fiscal years 1982-84. The paper entitled "Policies and Program Directions for 1982-84," provides information about issues, policies, and actions under consideration by AoA. An additional goal of the paper was to stimulate further thought and comment from the aging network on issues facing AoA and the network in meeting the needs of older persons. AoA issued an information memorandum to State and area agencies distributing a draft of the paper for discussion and comment. The paper has also been distributed to national aging organizations, Members of Congress, national policy centers on aging, the long-term care gerontology centers, and others, for discussion and comment. AoA has conducted briefing sessions on the paper for several national aging groups and for congressional staff. Comments have been received on the paper from State and area agencies and other organizations in the field of aging.

—AoA revitalized the celebration of Older Americans Month. The 1982 theme "Aging Together" emphasized strengthening intergenerational linkages. AoA inaugurated a series of Commissioner forums. These forums, of which two per year are planned, focus on key issues affecting older persons. The purpose of the forums is to stimulate dialog and the generation and sharing of ideas on these issues. The forums bring together experts who offer presentations on the issues under consideration and engage in discussions with each other and with the audience. The first of these forums was held during Older Americans Month, May 1982.

—During fiscal year 1982, AoA prepared position papers and played a key role in the development of plans and programs for the World Assembly on Aging, an international conference sponsored by the United Nations, which addressed issues facing older persons worldwide. The Secretary of Health and Human Services, the Assistant Secretary for Human Development Services, and the U.S. Commissioner on Aging participated in this conference.

—AoA provided assistance and staff support for the planning and conducting of the White House Conference on Aging, which was held in Washington, D.C., November 30 throught December 3, 1981. Following the Conference AoA also provided assistance in preparing reports on Conference proceedings and in examining methods for implementing Conference recommendations. The policies and recommendations of the White House Conference on Aging are being reflected in the "Policies and Program Directions for 1982-84" paper.

—During the past year several cooperative initiatives involving both the public and private sectors were begun. AoA worked with the National Institute for the Food Service Industry to undertake a joint training project to enhance the managerial skills of the State and area agencies' staff with respect to food service sanitation at service provider sites. Another example is the use of science and technology to benefit older persons. Work underway includes the development of a model for collaborative efforts between the aging network and public and private laboratories in order to increase volunteer opportunities and leadership roles for older persons in technology utilization efforts. Efforts to increase the commercialization of products and services that will benefit older persons are also being explored.

—In fiscal year 1982, AoA established an initiative to assist and promote increased labor force participation of older persons. One element of the initiative is a cooperative agreement with the American Management Associations to increase the number of small business employers knowledgeable about hiring and retraining older persons. A series of employer workshops will be held across the country to acquaint employers with the advantages older workers offer to small business owners.

SECTION II. TITLE III, SUPPORTIVE AND NUTRITION SERVICES

A. TITLE III—OVERVIEW

Under title III of the Older Americans Act, the Administration on Aging annually awards grants to the States to develop greater capacity and foster the development of comprehensive and coordinated service systems to serve older individuals, to "* * * (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; and (3) provide a continuum of care for the vulnerable elderly."

The law requires the designation of an agency within each State to be specifically responsible for carrying out the purposes of the act. This State agency on aging is required to subdivide the State into planning and service areas (PSA's) and to designate for each PSA an area agency on aging (AAA). Because of their small geographic or population size, 13 States have been allowed to designate the entire State as a single PSA with the State agency performing the area agency functions. Funds are made available to the States upon approval of State plans by AoA regional offices. States then allocate funds to area agencies based upon approved area plans. Funds provided to area agencies are utilized for the administration and support of a wide range of community-based supportive and nutrition services authorized under parts B and C of title III.

The title III activities conducted in the States during fiscal year 1982 were based upon 3-year plans approved beginning in fiscal year 1981. Four separate allocations were made to the States for: (a) State agency administrative and advocacy activities; (b) supportive services and senior center operations; (c) congregate nutrition services; and (d) home-delivered meals. (See appendix II for State allotments under title III in fiscal year 1982.)

The States made awards to the area agencies, based upon their approved area plans, to pay up to 85 percent of the costs of supportive services and senior centers and for nutrition services. In most cases, area agencies then arrange with both nonprofit and proprietary service providers to deliver nutrition and other services described in the area plan.

At the State and local level, the State and area agencies are charged with performing roles of advocacy and coordination similar to the responsibilities of AoA at the national level. They review and comment on State and community policies, programs, and issues; provide testimony at public hearings; publish reports; coordinate and provide technical assistance to other public and private agencies and organizations; and leverage resources from Federal, State, and local programs as well as private charitable and business resources.

In fiscal year 1982, AoA developed and began implementation of two initiatives to help the State and area agencies position themselves to meet increased demands for services at a time when economic recovery depends upon restraint in Federal expenditures.

The first initiative is intended to increase voluntary contributions from program participants. Title III regulations require that each service provider must "provide each older person [receiving services] with a full and free opportunity to contribute toward the cost of the service."

In addition to encouraging contributions by service recipients, the first initiative is also designed to improve program and financial management and accountability. The second, and closely related, initiative is to provide technical assistance to area agencies in adopting performance-based contracting for services provided under title III.

Activities relating to these initiatives will continue during fiscal year 1983. Goals for increasing program income have been set at 17 percent above the fiscal year 1981 level for fiscal year 1982; and at 50 percent above the fiscal year 1981 level by the end of fiscal year 1983. The actual increase in fiscal year 1982 was $21.8 million or 27.6 percent above the $79 million of program income for fiscal year 1981.

B. STATE AGENCIES ON AGING

Fifty-seven States and other jurisdications receive support under title III of the act. Currently all States and jurisdictions are operating under 3-year plans. The 1981 amendments to the act provide greater flexibility to State agencies by permitting them to elect durations of 2, 3, or 4 years for State and area plans. During fiscal year 1982, none of the State agencies exercised their option by changing to either a 2- or 4-year planning cycle.

State agencies are organizationally located in State governments either as independent agencies reporting directly to the Governor, or as components of larger human services agencies. In fiscal year 1982, there was a total of 1,821 persons on the staff of State agencies, including 162 older persons. States have established a total of 680 planning and service areas throughout the Nation.

In fiscal year 1982, States expended $48,682,978 of title III and matching funds for State agency activities. The activities undertaken include advocacy, provision of assistance to area agencies, and development of the State plan.

In addition, State agencies used $3,886,764 of title III–B (supportive services) funds to establish and maintain long-term care ombudsman programs. The 1981 amendments to the act required States to extend their services and protection of older persons to residents of certain types of boarding homes. Through their ombudsman programs, States have addressed such issues as nursing home regulations, abuse of resident's personal funds, and restrictions on access to nursing homes.

C. AREA AGENCIES ON AGING

In fiscal year 1982, there were 676[1] area agencies on aging operating under title III of the act. An area agency on aging may be a public or private organization, an Indian tribe, or a sub-State regional body. Area agencies have the major responsibility for the administration of funds for title III-B supportive services and title III-C nutrition services. Area agencies receive their funds from the State agency and then award grants and contracts to local supportive and nutrition service providers under an approved area plan. Area agencies are responsible for providing technical assistance to, and monitoring the effectiveness and efficiency of, their respective service providers. Through their coordination and planning activities area agencies serve as focal points for addressing the concerns of older persons at the community level in their area. Area agencies interact with other local public and private agencies and organizations in order to coordinate their respective activities and elicit or "leverage" additional resources to be used on behalf of older persons.

In fiscal year 1982, there was a total of 10,883 persons on the staffs of area agencies, including 2,695 older persons. The staffs are augmented by approximately 59,153 volunteers throughout the Nation.

Area agencies and single planning and service areas received a total of $578,980,669 of title III funds during fiscal year 1982. Of this amount, $541,028,832 was used for supportive and nutrition services, and $37,951,837 was spent for administrative purposes. Area agencies augmented their title III funds through eliciting $580,255,866 in support from other State and community sources.

Area agencies used a total of $225,987,686 for title III-B supportive services[2] during fiscal year 1982. Access services such as transportation, outreach, and information and referral accounted for $101,699,300 of this amount. In-home services, such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance were supported with $37,247,936. Legal services for older persons accounted for $13,538,353. Other community and neighborhood services such as residential repair, alteration and renovation, health services, physical fitness programs, and preretirement and second career counseling was supported by $73,502,097. The total number of older persons served in fiscal year 1982 by these services is estimated at 9.1 million persons. This includes approximately 1.6 million minority (18 percent) and 4.7 million (52 percent) low-income older persons. A total of 8,610 providers participated in the delivery of supportive services to these 9.1 million older persons.

Area agencies used $315,041,146 of title III-C for nutrition services in fiscal year 1982—$246,562,359 for congregate nutrition programs and $68,478,787 for home-delivered nutrition services. The nutrition services programs served an estimated 190 million meals during fiscal year 1982, at an average cost of $2.46 per meal, to approximately 3.3 million older persons. This included an estimated 2 million low-income and 603,805 minority older persons.

Title III-C nutrition services were provided to approximately 2.8 million persons over 60 and their spouses at 13,246 congregate nutrition sites throughout the country. These sites employed 24,498 paid staff and 189,038 volunteers. An estimated 500,000 persons received home-delivered nutrition services from 6,204 providers who employed 12,295 paid staff and 89,852 volunteers.

SECTION III. TITLE VI GRANTS TO INDIAN TRIBES

The purpose of title VI is to promote the delivery of supportive services, including nutritional services, for Indians that are comparable to services provided under title III of the act. Title VI allows federally recognized tribal organizations to apply to AoA for direct Federal funding. AoA initiated this program in fiscal year 1980. Although title VI-funded services must conform with many title III requirements, title VI is unique in the flexibility it provides to tribal organizations to tailor services in ways that make them responsive to Indian customs and cultures. However, older Indians receiving services under title VI cannot, by law, also receive services through programs funded under title III.

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[1] As of the end of fiscal year 1982, there were 680 planning and service areas but only 676 area agencies on aging. This was because State agencies on aging had assumed responsibility for operating service programs under title III in several planning and service areas.

[2] The 1981 amendments to the act changed the requirement that each area agency spend at least 50 percent of its title III, part B social services allotment for certain specified services (legal services, access services, and in-home services). This requirement has been replaced with a new requirement that the area agency spend "an adequate proportion" of title III-B funds for such services.

The Older Americans Act Amendments of 1981, which the President signed on December 29, 1981, effected several changes in title VI. These changes include:

(1) The requirement that service eligibility be restricted to persons 60 years of age or older has been eliminated. Now persons only need to be "older Indians," as defined by the tribe, to be eligible for services. However, the tribe must state the basis which it uses in defining "older Indians." The age criteria is now left to the discretion of the tribal organization as long as it maintains a statutory service population of at least 75 Indians age 60 or over.

(2) Nutrition services must continue to be made available but they do not have to be provided with title VI funds if funds from another source (other than title III) can be utilized. In any event, nutrition services provided must still be substantially in compliance with provisions of part C of title III.

(3) Information and referral (I&R) services are still required. However, title VI funds need not be expended as long as I&R services are provided to assure Indians reasonably convenient access to services and opportunities.

(4) Legal and ombudsman services are no longer required. However, when these services are provided they must substantially comply with title III requirements.

The result of these changes is to provide the tribes with greater flexibility in selecting services most appropriate to their needs. Nutrition and information and referral services are the only services that are required and these services can be made available with non-OAA funds. The effect is that title VI funds can be used to provide additional supportive services. For example, transportation, homemaker, and chore services can be provided. In addition, title VI funds can be used for road clearing, fuel, temporary shelter, and for acquisition, alteration, renovation, or staffing of facilities to be used as multipurpose senior centers.

During fiscal year 1982, AoA continued to implement a system for program monitoring and financial reporting that parallels the system used in title III. AoA also continued to administer a contract funded under its title IV-A education and training program to provide training and technical assistance to the tribal organizations for the administration of their grants. Of the 84 Indian projects in operation in fiscal year 1981, 83 received continuation funding in fiscal year 1982 for the third year of operation. One grantee elected not to continue participation. Six of the 83 Indian grantees received grants in fiscal year 1982 as part of the OHDS cooperative management initiative, an experiment to encourage joint funding and joint tribal management in tribes which receive funding from AoA as well as from the Administration for Native Americans and the Administration for Children, Youth, and Families. The 83 grantees received a total of $5.735 million under title VI. No new projects were established. (See appendix III for a summary and listing of fiscal year 1982 title VI grantees.)

SECTION IV. AoA DISCRETIONARY PROGRAMS

INTRODUCTION

Title IV of the Older Americans Act, as amended, authorizes a program of discretionary grants and contracts to support training and education, research and demonstration, and other activities. The purpose of these activities is to develop the necessary knowledge and information base to assist AoA and the State and area agencies on aging to carry out the goals, objectives, and program services set forth in the act. This section describes the AoA activities during fiscal year 1982 for title IV, part A—education and training, and part B—research, demonstrations, and other activities. This section also includes a description of the major long-term care initiatives undertaken by AoA in fiscal year 1982. (See appendix IV for a summary of AoA discretionary programs budget for fiscal year 1982.)

A. TITLE IV-A—EDUCATION AND TRAINING

Section 411 of the act authorizes the award of grants and contracts to assist in recruiting persons to enter the field of aging, training volunteers and persons employed in or preparing for employment in the field of aging, technical assistance, and other activities related to such training. In fiscal year 1982, a total of $7,712,735 was available to support education and training under this section of the act. A brief description of major activities is presented below:

State education and training program.—This program provides funds to each State agency on aging to support training and technical assistance to improve the knowledge, skills, and performance of State and area agency and service provider staff. In addition, this program promotes inter- and intra-State activities which bring together the resources of agencies and organizations concerned with education and training in the field of aging. AoA contined support in the amount of $3,588,730 to State agencies in fiscal year 1982.

Gerontology career preparation program.—The purpose of this program is to support the development of gerontological instructional programs in postsecondary educational institutions. Preservice training is provided for those planning careers in the field of aging. In fiscal year 1982, $2,590,639 was awarded to 31 new projects—17 graduate and professional school projects, 11 2- and 4-year school projects, and 3 joint projects with State units on aging and academic institutions relating to certification programs in aging. Two awards totaling $175,624 were awarded to continuation projects.

Technical assistance.—In fiscal year 1982, under contract with AoA, Birch & Davis, Inc., of Silver Spring, Md., developed three financial management handbooks that address financial management and accounting procedures of State and area agencies and service providers and one manual to be used in the assessment of fiscal procedures of AAA's and service providers. The contractor also produced a guide to be used in training State agencies and regional office staff in the used of the handbooks. AoA printed and distributed the handbooks to the State and area agencies on aging in September 1982. Training on the use of the materials will be conducted in all 10 regions during the next year. This effort received no funding during fiscal year 1982.

In another technical assistance effort, a national training and technical assistance contract in the amount of $214,890 was awarded to the Community Nutrition Institute. AoA trained 310 State agency on aging, area agency on aging, and local provider staff in various aspects of nutrition program and fiscal management. In addition, a nutrition service training manual was prepared and disseminated to the aging network.

In fiscal year 1982, under a $261,613 contract with ACKCO, Inc., of Boulder, Colo., training and onsite technical assistance were provided to Indian aging projects funded under title VI of the Older Americans Act. An operations manual was also produced and distributed to the 83 Indian tribal grantees.

Historically black colleges and universities (HBCU) initiative.—The purpose of this program is to develop innovative techniques to increase the capacity of HBCU's to provide quality self-help education to older persons in the areas of housing, employment, transportation, and health promotion. In addition, the participating schools are developing methods for establishing and maintaining linkages between HBCU's and private sector organizations. Four awards totaling $348,447 were made in fiscal year 1982.

National continuing education and training program.—This is a multiyear national training and technical assistance program designed to develop and disseminate instructional materials, including self-instructional activities for practitioners in the field of aging. Training projects funded under this program emphasize improvement of services provided through the act. Six projects were funded in fiscal year 1982, in the amount of $191,659 in such areas as: Service delivery, arts and humanities, and in-home services.

Minority management training program in aging.—The purpose of this program is to increase recruitment, training, and placement of minority individuals in the field of aging. In fiscal year 1981, AoA awarded a project to the National Center and Caucus on Black Aged (NCBA) for a cooperative venture of the four national minority aging organizations to recruit minority persons into State and area agencies on aging for training in administrative positions. In fiscal year 1982, AoA supported traineeships for 23 minority professionals in eight State agencies and 15 area agencies. Over half of those trainees were placed in permanent positions in the aging network. A continuation award in the amount of $341,133 was made to NCBA to support new trainees during 1982-83.

(See appendix V for a listing of awards made under title IV-A, section 411 in fiscal year 1982.)

B. MULTIDISCIPLINARY CENTERS OF GERONTOLOGY

Title IV-A, section 412 of the act, authorizes the award of grants to public and private nonprofit agencies, organizations, and institutions for the purpose of establishing or supporting multidisciplinary centers of gerontology, and gerontology centers of special emphasis.

1. National Policy Centers

In fiscal year 1982, AoA continued six national policy centers, which were originally funded in fiscal year 1980. The national policy centers did not receive any new funding during fiscal year 1982. During the past year the centers were engaged in policy analysis and development; policy research; and the preparation of personnel for undertaking work in these areas and for teaching these skills to others. An important task of each center was to develop a conceptual framework describing all of the major policy issues falling within the substantive purview of the center and indicating the significance of each issue. Where appropriate and available, references to data sources pertinent to each center's substantive domain are also included as part of the conceptual framework. Another important task was to respond to a limited number of requests from AoA for assistance. Typically, these requests involved policy analysis.

The subject matter, location, activities, and key products for the policy center during fiscal year 1982 are listed below:

Center on income located at Brandeis University.—Activities and key products: The adequacy of inflation adjustments in pensions; the impact of pensions on ethnic minorities; the economic condition of older women; implications of disability policy for old age; the level of benefits provided by pensions; possibilities for coherent reform in income maintenance policies.

Center on leisure, education, and continuing opportunities located at the National Council on Aging.—Activities and key products: Education and an aging society; voluntary action and older adults; leisure opportunities for cultural expression and contributions by older adults.

Center on health located at the University of California-San Francisco.—Activities and key products: policies for self-care and health promotion: the role of AoA and State and area agencies on aging; exercise and the elderly; current nutrition policy and future policy directions in nutrition education for the elderly; impact of State discretion under block grants in providing health and social services for older persons; policy implications for AoA and State and area agencies on aging; State adjustments in medicaid and title XX programs: Implications for health and human services for the elderly; the influence of State policy on residential care facility supply.

Center on older women located at the University of Maryland.—Activities and key products: Assessments of the impact of changing demographic trends on older women in the following areas: Health status, employment status, mental health status, and income status.

Center on employment located at the University of Southern California.—Activities and key products: The future structure of employment opportunities; private pensions and employment opportunities for older workers; employer costs in the development of worklife extension policies; management policy on aging in the work force; costs of pension accrual after age 65; negative versus positive incentives to encourage early retirement.

Center on housing and living arrangements located at the University of Michigan.—Activities and key products: Housing needs, current and projected; current private sector resources to meet housing needs; incentives for private industry to devote more resources to meet housing needs; alternative forms of housing for older persons.

2. Long-Term Care Gerontology Centers

The long-term care gerontology centers are also funded under title IV-A, section 412. The centers are discussed in the long-term care section of this report.

C. TITLE IV-B RESEARCH AND DEVELOPMENT

Title IV-B, section 421, research and development, authorizes funds to identify and assess new approaches and methods for improving the life circumstances of older persons. The primary objective of the program is to develop and disseminate knowledge and information which may be applied by policymakers, program managers, and practitioners concerned with the well-being of older persons. Particular attention is directed toward the needs of the very old and impaired whose problems are exacerbated by social isolation, low income, minority, and/or rural status. In fiscal year 1982, a total of $1,653,075 was available to support research and development projects. Of this amount, $690,779 was used to continue six projects initiated in previous years, and $962,296 to support eight new projects.

Fiscal 1982 continuation projects.—Previously funded projects which received continuing support in fiscal year 1982 encompass the following topical areas:

—*Health care, social and community-based services.* Two projects totaling $106,725 in this area emphasized the improvement of the quality and the effectiveness of the delivery of health and social services to older persons. Issues examined include demand for and use of health and social services, eligibility, and administrative policies that affect accessibility, quality, delivery, and coordination of services.

—*Older people, families, and the community.* One project in the amount of $94,785 in this area trained and supervised high school students to provide assistance to impaired older persons. The approach developed includes an objective of establishing an ongoing training program for students.

—*Housing and living arrangements.* This project for $30,000 studied older tenants in federally assisted housing sites in 1966–68, and again 12 to 14 years later in order to determine how the tenants' circumstances had changed, whether service needs had changed, and the suitability of the housing environment within the community context.

—*Special projects.* Two projects totaling $459,269 which were continued in fiscal year 1982, addressed the need for improving methods of disseminating research findings and encouraging their utilization.

Fiscal year 1982 new projects. The eight new research and development projects funded in fiscal year 1982, addressed the following objectives:

—*Promote opportunities for older persons to secure and maintain independence and self-sufficiency, thereby reducing the need for publicly supported social services.* A promising new idea for increasing the economic independence of older persons is home equity conversion. Two projects totaling $269,271 are promoting the development of new financing mechanisms that allow older persons to convert part of the equity in their home into income, while enabling them to continue living in their homes. A third project in the amount of $25,017, which also addresses independent living, seeks to improve the quality of life for millions of older persons who reside in special housing facilities. This model is developing a professional management program which will train managers, owners, and executives in the housing industry to improve living conditions of older tenants, assure older persons access to support services, and potentially reduce the need for costly institutionalization. A fourth project in the amount of $179,266 related to reducing reliance on publicly funded social services is an evaluation of the effectiveness of strategies for recruiting community volunteers to provide services and assistance to older persons.

Two projects totaling $333,742 seek to strengthen the capacity of public agencies with respect to meeting the need of older persons at risk. One is developing a reliable and valid instrument to measure and assess elder abuse. The instrument will be widely disseminated to agencies working with older persons, along with a package of training materials. The second project is evaluating public congregate housing programs to determine whether they are successful in reducing the risk of premature institutionalization among older persons.

One project funded in the amount of $55,000 analyzes both research and practice materials on volunteers and natural support systems and develops guidance for more effective widespread use of volunteers in service to Hispanic older persons in both rural and urban settings.

—*Encourage State and local development of service systems for older persons.* A project in this area, which received $100,000 from AoA in fiscal year 1982, is assessing in one State the design of human services block grants to county governments. It is examining the extent to which human services block grants lead to consolidated programs for various population groups, particularly older persons. The objective is to identify successful practices and disseminate this information to other States.

(See appendix VI for a listing of projects funded under title IV–B, section 421.)

D. TITLE IV–B, DEMONSTRATION PROJECTS

Title IV–B, section 422, authorizes the award of grants or contracts to support model projects which demonstrate methods to improve the well-being and independence of older persons. The program seeks to test and demonstrate effective new mechanisms, systems, or approaches for providing and delivering services. The program is also designed to improve the coordination and quality of social and other services for older persons, to facilitate the exchange of information, and to assist in the national use of project findings. AoA invested $8,506,230 in fiscal year 1982, to support new demonstration projects, and to continue projects funded in prior years.

Fiscal year 1982 continuation projects.—In fiscal year 1982, AoA continued to support 31 projects funded in previous years under the following categories:

—*National organizations.* Projects in this category are designed to promote a better partnership between AoA, national organizations, and the aging network to improve capacity to plan for and deliver services to underserved older persons. Four national organizations which represent minority populations exclusively recieved funding during fiscal year 1982. Seven other awards were made to organizations serving the older population in general. The 11 awards totaled $1,613,282 in fiscal year 1982.

—*State data reporting systems.* The six projects in this area foster the development of State systems for improving data collection, storage, reporting, and computerization of data pertaining to aging programs. The funding level for fiscal year 1982 was $555,537.

—*Services in rural areas.* In fiscal year 1982, AoA continued support of five projects in the amount of $291,929 in this area. These are designed to demonstrate models for effective linkages, joint planning, and coordination with other local institutions and organizations. For example, projects are designed to demonstrate how rural area agencies on aging can perform a catalytic role in the community and how those agencies can obtain support to carry out improved programs in conjunction with other public and private organizations at the local level.

—*Elderly abuse.* In fiscal year 1982, AoA continued three projects totaling $225,489 in this area which are concerned with determining the extent of elder abuse, identifying mechanisms for treatment and prevention, and exploring ways in which traditional protective services can be enhanced and coordinated with other social services to provide services for all older persons who are at risk of abuse.

—*Services to minorities.* The four projects funded in this area focus on the capacity of area agencies to serve minority older populations. They are designed to improve the services to minority clients. The funding level for fiscal year 1982 totaled $290,000.

—*Enhancement of services to migrants, refugees, and immigrants.* The purpose of these two projects is to enhance the quality of services delivered to older migrant, refugee, and immigrant populations by area agencies located in communities where large numbers of these populations reside. The fiscal year 1982 level is $153,770.

—*Legal and ombudsman services.* In fiscal year 1982, AoA continued to provide grants from title IV in the amount of $2,852,000 to State agencies on aging [3] to support the establishment and development of long-term care nursing home ombudsman programs, legal services, and protective services for older persons. As part of the application process for fiscal years 1982 and 1983, each State submitted a report on accomplishments in achieving their objectives in these three program areas. AoA is currently analyzing the results and accomplishments from each State and is preparing a summary report on the national ombudsman, legal services, and protective services program.

Fiscal year 1982 new projects.—A variety of new projects were funded during fiscal year 1982. The following examples indicate the types of projects undertaken:

—*Mental health.* Two new projects were funded totaling $202,383 in fiscal year 1982 to improve mental health services for older persons. These efforts focus on enhancing and increasing coordination between mental health and aging agencies at the State, regional, and county levels, and facilitating linkages among local providers of mental health and aging services.

—*Public policy options.* In fiscal year 1982, three projects totaling $225,649, were funded to encourage the use of government's broad powers (local, State, and Federal) to solve human service problems without relying unnecessarily on direct use of public funds. Public policy options (also referred to as "indirect services" and "governance") are a supplement to direct delivery of services. They involve use of governance powers to: (1) Increase the supply of needed goods and services; and (2) to solve problems of access to them. AoA, SRI International (a nonprofit research organization), the U.S. Conference of Mayors, and the National Association of Counties, are involved in a cooperative effort whose purpose is to help strengthen the role of State agencies on aging and area agencies in encouraging the use of governance powers. AoA also provided funding in collaboration with OHDS to demonstrate the application of indirect services in seven sites.

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[3] In addition, the States spent $3,886,764 from their title III-B allocations to operate the ombudsman program and $13,538,353 to provide legal services in their jurisdictions.

—*Management.* AoA made three new awards totaling $561,811 as part of its continuing efforts to strengthen the capacities of State and area agencies on aging in managing and improving services. One award supported the design of an easy-to-learn management information system for local agencies for client tracking and for estimating service costs. A second focuses on the development of management indicators to improve State administration and local service delivery, while a third will enable States to develop alternative social service interventions.

—*Housing.* One new project in the amount of $89,933 was funded in fiscal year 1982 in this priority area. This award supports a project in which buildings are transferred from individual ownership to group ownership. Funds from non-AoA sources are used to renovate selected buildings to meet local building requirements.

—*Volunteerism.* In fiscal year 1982, AoA made two new awards totaling $210,790 to stimulate volunteerism. One project plans to develop a corps of volunteers, and to train and station the volunteers at 26-six service sites throughout a rural county. These volunteers will provide regular visits, maintenance assistance, transportation, and other person-to-person services to older persons to encourage independent living. The project's goal is to demonstrate an effective model for organizing volunteers and raising support through private sector contributions. A second project will: (1) Develop a profile of current human services agency volunteers for use in recruiting future volunteers, and (2) develop an automated data base for use as a clearinghouse in matching skills of newly recruited volunteers with agency needs. The projects also will implement a public service advertising and marketing campaign designed to increase volunteers, and produce a self-administered training manual. The goal of the project is thus to substantially increase the number of volunteers in public and nonprofit human service agencies.

—*Community services.* Two projects totaling $328,281 of AoA support for fiscal year 1982 seek to reform Wisconsin's system of long-term support through improved consumer training and knowledge, use of vouchers to enable direct consumer-provider interaction, and improved access to an increased supply of providers. The focus of one of these projects is the transfer of substantial authority for the provision of long-term care services from State to local level. In addition AoA supported a project in the amount of $143,701 that is providing linkage between social services and the criminal justice system.

—*Science and technology.* In fiscal year 1982, AoA made three new awards totaling $305,000 to stimulate the use of science and technology in meeting the needs of older persons. One project is addressing the needs of the older population through the application of emerging technologies and is showing how the technology commercialization process in the private sector can work in improving the quality of life for our Nation's older persons. The second project is fostering productive working relationships between retiree volunteers who have business and scientific backgrounds and the aging network. In addition, it is initiating new partnerships between the aging network and the public and private sectors in the areas of technology transfer and technological innovation. The third project is increasing volunteer opportunities for older persons in technology transfer efforts.

—*Disaster assistance.* Grants totaling $81,500 went to States in regions I, V, and IX to reimburse those States for funds made available to area agencies on aging for delivery of supportive services during major disasters declared by the President in accordance with the Disaster Relief Act of 1974.

—*Intergenerational.* AoA supported in the amount of $13,700, a joint effort with the Administration for Children, Youth, and Families (ACYF) that is examining the utilization of retired older persons in day care centers serving children.

(See appendix VII for a listing of projects funded under title IV–B, section 422.)

E. LONG-TERM CARE (LTC)

Title II, section 202(b) and title IV–B, section 423 assign AoA the responsibility to participate in departmental and interdepartmental activities which concern issues of institutional and noninstitutional long-term health care services development. The 1981 amendments to the act broadened the long-tern care responsibility of AoA and State and area agencies on aging to include "board and care homes" of the type covered by the Keys amendment to the Social Security Act. In fiscal year 1982, AoA spent a total of $7,405,877 (including $3.2 million for evaluation of the channeling demonstration) to initiate new projects and continue previously funded long-term care (LTC) projects.

AoA's long-term care activities support the improvement of policies, programs, and systems which enhance the opportunity for functionally impaired older persons to secure and maintain maximum independence and self-sufficiency. The mission addresses basic goals of the Department—to serve those most in need—as well as the goals of AoA—to insure that services or other appropriate assistance is available to those older persons in need.

The purpose of AoA's long-term care activities is to develop more effective and less costly solutions for problems resulting from a rapidly increasing functionally impaired older population and from the escalating costs of health care, personal care, and social services which already exceed available public resources. These initiatives support State and area agencies in planning, coordinating, and managing services intended to address the problems of highly vulnerable older persons.

AoA's long-term care activities are organized under the following five program components:

1. Long-Term Care Policy Analysis

There are two major activities in this area: (a) The National Conference on Social Welfare and the Center for the Study of Social Policy developed and disseminated information about long-term care policies to State and local agencies and other selected audiences. This project received $15,000 in fiscal year 1982, and was completed in June 1982. (b) The appropriateness of care initiative is intended to promote the increased use of nontraditional types of services and increased private sector activity in the provision of alternative community living arrangements and case management services. As part of this initiative AoA developed a profile, based on national data sources, of its client population. AoA administered a field study, using a mail questionnasire and/or telephone or personal interviews, which gathered information on case management services and alternative community living arrangements from State and local service providers, administrators, and planners. These efforts, which were completed in September 1982, did not receive funding during fiscal year 1982.

2. National Long-Term Care Initiative

This departmental initiative is aimed at developing a knowledge base drawn from research studies and demonstration projects to serve as a foundation for policy and program development and capacity building at the State and local levels. AoA is participating in this initiative along with the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. In fiscal year 1982, AoA supported this initiative with $3.2 million of title III funds, since only the channeling demonstration evaluation received AoA funding during fiscal year 1982. This initiative is comprised of the following interrelated components:

a. Long-term care data base

(1) Analysis and synthesis of existing LTC data were conducted to make estimates of the distribution and mix of impairments, the supply, utilization, and cost of formal and informal services, and the outcomes of long-term care services.

(2) The U.S. Bureau of the Census completed field work on a national household survey to determine the incidence and extent of functional impairment among persons 65 and over, and the need, demand, and utilization of health care, personal care, and social services.

b. State long-term care system development

AoA supported the development of a LTC planning structure at the State level and a State LTC plan based on assessment of needs and resources. LTC plans were developed and implemented in 15 States during fiscal year 1982.

c. Channeling demonstrations

The purpose of these demonstrations is to develop organizational structures and operating procedures at the community level to match resources with identified needs for various types of continuing care. The demonstration sites are also provided technical assistance with the planning and implementation of their activities. Evaluation of process and outcomes is a major part of the demonstration effort.

The LTC channeling demonstration program is testing different models for linking older persons with appropriate types of long-term care at community-level sites. Five of these sites are experimenting with a "case management" model while another five are using a "financial control" model. These two models share a core set of functions: Outreach, screening, comprehensive needs assessment, care planning, and case management (arranging for services, monitoring, and reassessment).

The two models diverge in several important respects: Their authority to arrange for services, their reliance on the existing services and public programs, and their approach to cost containment. The "case management" model, through the core functions cited above, relies on the case manager to negotiate access to existing services and to make efficient use of them. The "financial control" model, in contrast, confers authority on the case manager to authorize and purchase services out of a pool of funds without respect to many important existing program requirements, such as income eligibility. It does, however, impose strict controls on costs through caps on program and individual expenditures, and requires cost-sharing by clients with higher incomes.

3. Long-Term Care Gerontology Centers

By mobilizing the resources of a number of universities and collaborating with community-based public and private sector agencies, AoA undertook the following programmatic activities:

(a) Development and evaluation of models for the provision of long-term care.

(b) (Development of professional and paraprofessional staff for the delivery of health care, personal care, and other services through career and continued education and training.

(c) Development of policy, applied and clinical research to improve conditions for the functionally impaired older persons; and

(d) Information dissemination and technical assistance to State and local public and private agencies.

Through research, education, and service activities involving university faculty, agency planners, managers, and practitioners, these centers assist their local community, State, and region, in developing and implementing more cost-effective and efficient LTC policies, programs, and systems. Centers are located in each of the 10 DHHS regions and serve as major resources to State and community agencies in efforts to address the long-term care needs of older persons.

Five centers were established in fiscal year 1980, and an additional four were funded in fiscal year 1981. In fiscal year 1982, the first group of five centers were refunded at a total of $2,867,811. In addition, three planning awards were made for a total of $294,115, in the two regions where centers had not yet been established. A technical assistance effort to facilitate information exchange and organization development among the LTC Gerontology Centers were funded in the amount of $101,948 in fiscal year 1982.

4. Geriatric Fellowship

The purpose of this program is to develop a faculty capability for orienting medical students to geriatrics and gerontology. AoA has made awards to six institutions to support two fellows each for a period of 2 years. A total of $444,536 was awarded through the geriatric fellowship program in fiscal year 1982.

5. Research and Demonstration Projects

(a) Under and interagency agreement with the Health Services Administration, primary health care facilities were developed as model service delivery points for vulnerable older persons. Two projects, which had been funded in previous years, were active in fiscal year 1982.

(b) Among the new projects which were funded by AoA in the area of long-term care and/or community-based services to the vulnerable elderly, there are four that deal with the role of families in providing personal care and one project deals with residential care for adults. These demonstration projects were supported in fiscal year 1982 in the amount of $482,467.

(See appendix VIII for a listing of long-term care projects funded during fiscal year 1982.)

SECTION V. EVALUATION

Section 206 of the act provides for the evaluation of the impact of all programs authorized by the act. AoA's evaluation program in fiscal year 1982 involved the continuation of projects that were funded in prior years and the initiation of one new project. The following is a brief description of these evaluation activities:

Longitudinal evaluation of the nutrition program.—This project, which was funded during previous fiscal years, is a national longitudinal study of nutrition services provided under title III of the act. The major purposes of this study are: (a) To assess the utilization of nutrition and supportive serices by program participants; (b) to evaluate the operations, activities, and environments of congregate nutrition projects and meal sites, as well as, home-delivered meals; (c) to identify program characteristics and other factors that may influence the composition of the participant population, the frequency of their participation, and the benefits they receive; and (d) to provide information relative to participants' dietary status, degree of isolation, and capacity for independent living.

Evaluation of State education and training program.—This study, initiated and funded in fiscal year 1981, is sheduled for completion in the spring of 1983. The objectives are to determine how the program is performing in terms of agreed-upon objectives and performance indicators.

Evaluation of title VI grants to Indian tribes.—The purposes of this study, funded in the amount of $153,620 in fiscal year 1982, are to assess current title VI projects in order to better understand those factors associated with effective program development and management and to enhance AoA and local project performance under the title VI program. It is a 12-month study that will terminate in September 1983.

Evaluation of LTC channeling demonstrations.—This evaluation is discussed in the long-term care section of this report.

APPENDIX I

FY 1982 BUDGET ADMINISTRATION ON AGING

State and Area Agency Activities 1/	$ 21,673,000
Supportive Services & Senior Centers 1/	240,869,000
Nutrition Services 1/	344,099,000
Congregate Nutrition Services	(286,749,000)
Home-delivered Nutrition Services	(57,350,000)
Grants to Indian Tribes	5,735,000
Training, Research & Discretionary Programs and Projects	22,175,000
National Clearinghouse on Aging	1,721,000
TOTAL	$636,272,000

1/Up to 8.5% of the funds for Supportive Services and Senior Centers, and for Nutrition Services, may be used for Area Agency Activities.

APPENDIX II

FY 1982 ALLOTMENTS UNDER TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED P.L. 97-115

13.633 PI-82-42

State	Population 60+ Distribution Factor	Part A State Administration	Part B Social Services	Part C-1 Congregate Meals	Part C-2 Home Delivered Meals
AL	1.69018	300000.	3899468.	4613477.	922695.
AK	.05447	300000.	1199732.	1419408.	283883.
AZ	1.19679	300000.	2754986.	3262221.	652072.
AR	1.17294	300000.	2706158.	3201667.	640226.
CA	9.45746	1460760.	21819411.	25814638.	5162540.
CO	.97083	300000.	2239833.	2649526.	529953.
CT	1.44752	300000.	3339620.	3951115.	790227.
DE	.22907	300000.	1199732.	1419408.	283883.
DC	.29776	300000.	1199732.	1419408.	283883.
FL	6.24219	964190.	14401525.	17028500.	3407712.
GA	2.03364	314110.	4691870.	5553971.	1110158.
HI	.31632	300000.	1199732.	1419408.	283883.
ID	.36602	300000.	1199732.	1419408.	283883.
IL	4.91537	759214.	11340386.	13416855.	2683281.
IN	2.27372	351191.	5245750.	6206265.	1241258.
IA	1.44473	300000.	3333165.	3943482.	788655.
KS	1.14401	300000.	2639370.	3122650.	624522.
KY	1.56458	300000.	3609646.	4270635.	854130.
LA	1.56989	300000.	3621929.	4285120.	857027.
ME	.53215	300000.	1227728.	1452531.	290507.
MD	1.59861	300000.	3688106.	4362508.	872705.
MA	2.78638	430376.	6428525.	7605616.	1521129.
MI	3.62379	559720.	8360538.	9891288.	1978285.
MN	1.80537	300000.	4165209.	4927672.	985578.
MS	1.09043	300000.	2516693.	2977510.	595504.
MO	2.42454	374488.	5593726.	6617961.	1323597.
MT	.33095	300000.	1199732.	1419408.	283883.
NE	.75798	300000.	1748745.	2068948.	413791.
NV	.28127	300000.	1199732.	1419408.	283883.
NH	.39591	300000.	1199732.	1419408.	283883.
NJ	3.40596	526066.	7857847.	9296623.	1859327.
NM	.49642	300000.	1199732.	1419408.	283883.
NY	8.33116	1286794.	19220882.	22740208.	4548078.
NC	2.37685	367426.	5483383.	6493227.	1298672.
ND	.30084	300000.	1199732.	1419408.	283883.
OH	4.60167	710760.	10616635.	12560587.	2512126.
OK	1.40624	300000.	3244375.	3838424.	767685.
OR	1.16838	300000.	2695599.	3189175.	637837.
PA	6.00603	927796.	13858500.	16396651.	3279222.
RI	.48993	300000.	1199732.	1419408.	283883.
SC	1.15451	300000.	2663594.	3151210.	630264.
SD	.33872	300000.	1199732.	1419408.	283883.
TN	1.99093	307512.	4593314.	5434270.	1086878.
TX	5.28095	815624.	12182985.	14413742.	2882758.
UT	.42154	300000.	1199732.	1419408.	283883.
VT	.21975	300000.	1199732.	1419408.	283883.
VA	2.01597	311320.	4651086.	5502726.	1100548.
WA	1.69382	300000.	3907463.	4623489.	924688.
WV	.91738	300000.	2115502.	2504043.	500810.
WI	2.14054	320621.	4933456.	5842744.	1168553.
WY	.14664	300000.	1199732.	1419408.	283883.
PR	1.05640	300000.	2437245.	2883515.	576705.
GU	.01001	75000.	599866.	709704.	141941.
TT	.02065	75000.	599866.	709704.	141941.
VI	.01571	75000.	599866.	709704.	141941.
AS	.00257	75000.	149966.	177426.	35485.
N MA	.00256	75000.	149966.	177426.	35485.
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	100.00000	21673000.	239946310.	283881516.	56774256.

Amounts issued to State Agencies on individual grant awards reflect 100% of the annualized amounts listed above. Additional funds have been awarded to American Samoa in order to provide funding at the FY1978 level. These funds have been withheld from the amount reserved for evaluation.

Administration on Aging
Office of Human Development Services

August 20,1982

APPENDIX III

Grants under Title VI

ADMINISTRATION ON AGING

1982 Title VI Regional Information Chart
(September 30, 1982 - September 30, 1983)

Region	Total Title VI grants awarded by Region	Number of Indian Tribes that received Title VI funding, by Region and State	States within Region with tribes that received Title VI funding
I	1	1	Maine
II	1	1	New York
IV	2	1	Mississippi
		1	N. Carolina
V	13	3	Michigan
		3	Minnesota
		7	Wisconsin
VI	26	14	Oklahoma
		12	N. Mexico
VII	5	2	Nebraska
		3	Kansas
VIII	12	1	Utah
		1	N. Dakota
		2	Colorado
		3	S. Dakota
		5	Montana
IX	10	1	California
		2	Nevada
		7	Arizona
X	13	1	Oregon
		1	Alaska
		2	Idaho
		9	Washington
TOTAL	83	83	

APPENDIX III

LISTING OF TITLE VI GRANTEES
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Keweenaw Bay Indian Community Baraga, MI	$ 67,925
Stockbridge-Munsee Community Bowler, WI	$ 72,925
Red Cliff Band of Lake Superior Chippewas Bayfield, WI	$ 67,925
Inter-Tribal Council of Michigan, Inc. Sault Ste. Marie, MI	$ 74,825
Wisconsin Winnebago Business Committee Port Edwards, WI	$ 65,925
Mississippi Band of Choctaw Indians Philadelphia, MS	$ 19,675
Eastern Band of Cherokee Indians Qualla Indian Boundary Projects Cherokee, NC	$ 70,925
Tonawanda Band of Senecas Basom, NY	$ 67,925
Sault Ste. Marie Tribe of Chippewa Indians Sault Ste. Marie, MI	$ 72,925
Fond Du Lac Reservation Cloquet, MN	$ 74,825
Lac Courte Oreilles Hayward, WI	$ 72,925
Passamaquoddy Tribe Perry, ME	$ 67,825
Kiowa Tribe of Oklahoma Carneigie, OK	$ 18,425
Santo Domingo Tribe Santo Domingo Pueblo, NM	$ 70,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Pueblo of Taos Taos, NM	$ 79,825
Kickapoo Tribe of Oklahoma McCloud, OK	$ 100,925
Pawnee Tribe of Oklahoma Pawnee, OK	$ 84,825
United Tribes of Kansas and S.E. Nebraska Horton, KS	$ 65,925
Otoe-Missouria Tribe Red Rock, OK	$ 74,925
Quapaw Tribe of Oklahoma Quapaw, OK	$ 75,925
Five Sandoval Indian Pueblos, Inc. Bernalillo, NM	$ 22,800
Miami Tribe of Oklahoma Miami, OK	$ 84,825
Creek Nation of Oklahoma Okmulgee, OK	$ 100,925
Eight Northern Indian Pueblos Council San Juan Pueblo, NM	$ 67,925
The Chickasaw Nation Ada, OK	$ 69,925
Menominee Indian Tribe of Wisconsin Keshena, WI	$ 69,825
Santa Clara Pueblo Espanola, NM	$ 69,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Pueblo of San Juan San Juan Pueblo, NM	$ 72,925
Pueblo of Isleta Isleta, NM	$ 65,925
Seneca-Cayuga Tribe of Oklahoma Miami, OK	$ 74,825
Pueblo of Zuni Zuni, NM	$ 22,800
Red Lake Band of Chippewa Indians Red Lake, MN	$ 77,925
Bad River Tribe Ashland, WI	$ 69,825
Seminole Nation of Oklahoma Wewoka, OK	$ 77,925
Jicarilla Apache Tribe Duluce, NM	$ 65,925
Osage Tribe of Oklahoma Pawhuska, OK	$ 100,925
Pueblo of Laguna Laguna, NM	$ 72,825
Mescalero Apache Tribe Mescalero, NM	$ 69,825
Citizen Band Potawatomi Indians of Oklahoma Shawnee, OK	$ 74,925
Choctaw Nation of Oklahoma Durant, OK	$ 102,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Nebraska Indian Inter-Tribal Development Corporation-Omaha Tribe Winnebago, NE	$ 72,825
Mille Lacs Reservation Business Community Onamia, MN	$ 72,925
Cherokee Nation of Oklahoma Tahlequah, OK	$ 65,925
Nebraska Indian Inter-Tribal Development Corporation-Santee Sioux Tribes Winnebago, NE	$ 67,825
Pueblo of Acoma Pueblo of Acoma, NM	$ 72,825
Confederated Salish and Kootenai Tribes Pablo, MT	$ 74,825
Prairie Band of Potawatomi Indian Mayetta, KS	$ 65,925
Yankton Sioux Tribe Wagner, SD	$ 65,925
Northern Cheyenne Tribe Lame Deer, MT	$ 65,925
Blackfeet Tribe Browning, MT	$ 74,825
Southern Ute Community Action Programs Ignacio, CO	$ 65,925
Uintah and Ouray Business Committee Fort Duchesne, UT	$ 72,850
Kickapoo Tribe in Kansas Horton, KS	$ 67,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Chippewa - Cree Tribe Box Elder, MT	$ 70,925
Ute Mountain Ute Tribe Towaoc, CO	$ 70,925
Cheyenne River Sioux Tribe Eagle Butte, SD	$ 67,925
Oglala Sioux Tribal Pine Ridge, SD	$ 70,925
Assiniboine and Sioux Tribes Poplar, MT	$ 69,825
The Navajo Tribe Fort Defiance, AZ	$ 72,825
Salt River Indian Community Scottsdale, AZ	$ 17,675
Northwest Washington Service Unit Bellingham, WA	$ 70,925
Kodiak Area Native Association Kodiak, AK	$ 74,925
Shoshone-Bannock Tribes Fort Hall, ID	$ 74,925
Hupa Health Association, Inc. Hoopa, CA	$ 72,825
White Mountain Apache Tribe Whiteriver, AZ	$ 72,925
South Puget Intertribal Planning Agency Shelton, WA	$ 70,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Standing Rock Sioux Tribe Fort Yates, ND	$ 65,925
Papago Tribe Sells, AZ	$ 70,925
Pascua Yaqui Tribe Tucson, AZ	$ 72,925
Inter-Tribal Council of Nevada Reno, NV	$ 69,925
Confederated Tribes of the Umatilla Pendleton, OR	$ 75,925
Yakima Indian Nation Toppenish, WA	$ 65,925
Quinault Indian Nation Taholah, WA	$ 65,925
San Carlos Apache Tribe San Carlos, AZ	$ 65,925
Muckleshoot Indian Tribe Auburn, WA	$ 69,950
Puyallup Tribal Health Authority Tacoma, WA	$ 75,925
Lummi Indian Business Council Bellingham, WA	$ 70,925
Colville Confederated Tribes Nespelem, WA	$ 18,425
Hopi Tribal Council Kyakotsmovi, AZ	$ 75,925
Washoe Tribe of Nevada and California Gardnerville, NV	$ 65,925

LISTING OF TITLE VI GRANTEES (cont.)
FY 1982 Funding

Indian Tribe/Grantee	FY 1982 Funds
Eastern Washington Indian Consortium Wellpinit, WA	$ 72,825
Nez Perce Tribe of Idaho Lapwai, ID	$ 74,950
St. Croix Tribal Council Webster, WI	$ 67,925

APPENDIX IV

FY 1982 TITLE IV DISCRETIONARY BUDGET ADMINISTRATION ON AGING

Education and Training	$ 7,712,735
Multidisciplinary Centers of Gerontology 1/	$ - 0 -
Research and Development	$ 1,653,075
Demonstrations	$ 8,506,230
Long-Term Care Projects 2/	$ 4,205,877
Miscellaneous Costs	$ 97,083
TOTAL	$ 22,175,000

1/ The six National Policy Centers did not require funding during FY 1982. Funds for the Long-Term Care Gerontology Centers are shown under Long-Term Care Projects.

2/ This does not include the $3.2 million for evaluation of the Long-Term Care Channeling Demonstration Program.

APPENDIX V

TITLE IV-A, EDUCATION AND TRAINING
FY 1982 Projects

National Continuing Education and Training Program

Title	Recipient	FY 1982 Funds
Training of Service Providers in Establishing Arts and Humanities Programs for Older Adults	Cemrel, Inc. Washington, DC	$ 149,766
Delivering Services for Community Care of the Aged	Washington School of Psychiatry Washington, DC	$ 6,000
Supervisors In-Home Services	National Home Care Council, Inc. New York, NY	$ 6,893
Training on Cost Accounting and Generation of Increased Program Income	Phoenix Systems Spencer, IO	$ 9,500
Orientation of Aging Service Personnel to the Older Americans Act	National Association of State Units on Aging Washington, DC	$ 1,500
Continuing Education for Area Agencies on Aging: A Developmental Process	National Association of Area Agencies on Aging Washington, DC	$ 18,000
	Technical Assistance	
Technical Assistance and Training for Aging Organizations Involved in Management of Nutrition Services	Community Nutrition Institute Washington, DC	$ 214,890
Technical Assistance to Title VI Grantees	Ackco, Inc. Boulder, CO	$ 261,613

Gerontology Career Preparation Program

Title	Recipient	FY 1982 Funds
Building Capacity in a Gerontology Program	University of Bridgeport Center for Study of Aging Bridgeport, CN	$ 97,571
Training Aging Paraprofessionals	Middlesex Community College Gerontology Center Bedford, MA	$ 49,721
Mediating Structures and Gerontology Career Preparation	Hunter College Brookdale Center on Aging New York, NY	$ 88,368
Strengthening Private Sector Initiatives and Informal Support Systems	Fordham University Graduate School of Social Service New York, NY	$ 100,000
Training in Gerontology for Leadership Development	University of the District of Columbia Institute of Gerontology Washington, DC	$ 100,000
Gerontology Career Preparation: Models and Innovations	University of Maryland Center on Aging College Park, MD	$ 95,000
Development of Training Standards for Network Practitioners	Pennsylvania Dept. of Aging Bureau of Policy, Planning and Monitoring Harrisburg, PA	$ 100,000
Increasing the Effectiveness Services to Minority Elderly	Virginia Union University Gerontology Program Richmond, VA	$ 56,029
Gerontology Training Through Partnership	Norfolk State University School of Social Sciences Norfolk, VA	$ 90,494
Gerontology Information and Training Program	Hampton Institute Gerontology Program Hampton, VA	$ 100,000

Gerontology Career Preparation Program (cont.)

Title	Recipient	FY 1982 Funds
Model Training for Service Providers to Aging	Virginia Commonwealth University Virginia Center on Aging Richmond, VA	$ 99,991
Gerontology Career Preparation Program	Atlanta University Sociology/Gerontology Department Atlanta, GA	$ 100,000
Gerontology Training for Service Delivery to Minority Aging	Clark College Gerontology Program Atlanta, GA	$ 69,241
Joint Program for Gerontology Certification	Livingstone College Social Welfare Dept. Salisbury, NC	$ 58,450
Training for Volunteerism with the Elderly	University of South Carolina College of Social Work Columbia, SC	$ 25,545
Training and Development in Aging Service Delivery	Memphsis State University College of Arts and Sciences Memphis, TN	$ 27,426
A Collaborative Model Gerontology Paraprofessional Training	Elgin Community College Gerontological Dept. Elgin, IL	$ 72,067
Gerontology Career Preparation Program	University of Michigan Institute of Gerontology Ann Arbor, MI	$ 100,000
Development of Paraprofessional Curriculum on 'Open-Care'	Madonna College Gerontology Dept. Livonia, MI	$ 100,000
Training: Volunteers, Paraprofessionals, and the Network	Wayne County Community College Gerontology Program Detroit, MI	$ 100,000

Gerontology Career Preparation Program (cont.)

Title	Recipient	FY 1982 Funds
Preparing Paraprofessionals to Work with the Elderly	St. Scholastica College Behavioral Sciences Duluth, MN	$ 100,000
Learning by Doing: Minority Preparation of Practitioners Research Scholars and Career	Miami University (Ohio) Scripps Foundation Gerontology Center Oxford, OH	$ 100,000
Rural Gerontology Career Preparation Program	Ohio University Athens, OH	$ 100,000
Multidisciplinary Gerontology Career Preparation Program	Grambling State University Sociology/Anthropology Dept. Grambling, LA	$ 74,744
Model for an Integrated Approach to Career Preparation	North Texas State University Center for Studies in Aging Denton, TX.	$ 99,869
Training in Chicano Aging	University of Texas/Arlington Center for Chicano Aged Arlington, TX	$ 100,000
New Initiatives in Career Preparation and Partnership	Wichita State University University Gerontology Center Wichita, KS	$ 96,085
Undergraduate Gerontology Career Preparation Program	Weber State College Gerontology Program Ogden, UT	$ 70,502
Enhancing State-wide Community College System in Long-Term Care Education	University of Arizona Long-Term Care Gerontology Center Tucson, AZ	$ 35,300

Gerontology Career Preparation Program (cont.)

Title	Recipient	FY 1982 Funds
Clinical Training in Aging and Mental Health	University of Southern California Dept. of Psychology Los Angeles, CA	$ 100,000
Gerontology Career Preparation Program: Continuing Education, Consultation and Field Study	Oregon State University Program on Gerontology Corvallis, OR	$ 76,236
Gerontology Career Preparation	University of Hawaii Honolulu, HI	$ 94,269*
Gerontology Career Preparation	University of Southern California Andrus Gerontology Center Los Angeles, CA	$ 81,355*

Historically Black Colleges and Universities Initiative

Title	Recipient	FY 1982 Funds
Self-Help Skills Development Program for Older Adults	Cheney State College Cheney, PA	$ 87,198
Project Get in SHAPE (Spelman Health Awareness Project for the Elderly)	Spelman College Dept. of Continuing Education Atlanta, GA	$ 87,500
Employment Skills Development for Older Americans	North Carolina Central University Public Administration Program Durham, NC	$ 88,049
Home Care Maintenance for the Rural Elderly	Prairie View A&M University Community Affairs and Rural Development Prairie View, TX	$ 85,700

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*Continuation Projects.

Minority Management Training Program in Aging

Title	Recipient	FY 1982 Funds
Minority Management Training Program in Aging	National Center and Caucus on Black Aged Washington, DC	$ 341,133

State Education and Training Program

Recipient	FY 1982 Funds
Alabama	$ 53,388
Alaska	$ 30,000
Arizona	$ 36,267
Arkansas	$ 36,844
California	$ 303,206
Colorado	$ 31,496
Connecticut	$ 46,980
Delaware	$ 30,000
District of Columbia	$ 30,000
Florida	$ 189,835
Georgia	$ 62,520
Hawaii	$ 30,000
Idaho	$ 30,000
Illinois	$ 157,969
Indiana	$ 73,184
Iowa	$ 47,582
Kansas	$ 37,631
Kentucky	$ 49,974
Louisiana	$ 48,822
Maine	$ 30,000
Maryland	$ 50,854
Massachusetts	$ 90,836
Michigan	$ 115,850
Minnesota	$ 58,836
Mississippi	$ 33,993
Missouri	$ 78,159
Montana	$ 30,000
Nebraska	$ 30,000
Nevada	$ 30,000
New Hampshire	$ 30,000
New Jersey	$ 111,005
New Mexico	$ 30,000
New York	$ 272,573

State Education and Training Program (cont.)

Recipient	FY 1982 Funds
North Carolina	$ 73,792
North Dakota	$ 30,000
Ohio	$ 147,947
Oklahoma	$ 45,026
Oregon	$ 37,949
Pennsylvania	$ 193,926
Rhode Island	$ 30,000
South Carolina	$ 35,101
South Dakota	$ 30,000
Tennessee	$ 62,635
Texas	$ 166,712
Utah	$ 30,000
Vermont	$ 30,000
Virginia	$ 64,277
Washington	$ 53,361
West Virginia	$ 30,000
Wisconsin	$ 70,513
Wyoming	$ 30,000
American Samoa	$ 15,000
Guam	$ 15,000
Puerto Rico	$ 34,687
Trust Territory	$ 15,000
Virgin Islands	$ 15,000
N. Mariana Islands	$ 15,000

APPENDIX VI

TITLE IV-B, RESEARCH AND DEVELOPMENT
FY 1982 Continuations

Title	Recipient	FY 1982 Funds
Changing Service Needs of Older Tenants	Philadelphia Geriatric Center Philadelphia, PA	$ 30,000
Gerontological Research Institute	American Institute for Research Washington, DC	$ 59,952
Supporting Facilities for Research and Policy Development and Evaluation in the Field of Aging	University of Michigan Ann Arbor, MI	$ 399,317
Continuum of Long-Term Care: Health Care of the Elderly: Research Fellowship Program	Gerontological Society of America Washington, DC	$ 85,000
Youth Support System for Frail Elderly	University of Southern California Los Angeles, CA	$ 94,785
On Lok Senior Health Services	On Lok Community Care Organization for Dependent Older Adults San Francisco, CA	$ 21,725
	FY 1982 New Projects	
A Synthesis and Dissemination of Rural and Urban Programs	Coalition of Hispanic Mental Health Organizations Washington, DC	$ 55,000
Congregate Housing: How Does It Work and For Whom Does It Work Best	Dept. of Elder Affairs Boston, MA	$ 180,000

FY 1982 New Projects

Title	Recipient	FY 1982 Funds
Design of Human Services Block Grants to County Governments in Pennsylvania	Governor's Office of Policy and Planning Harrisburg, PA	$ 100,000
Volunteers and the Elderly: Effective Strategies for Recruiting and Retaining Volunteers to Aid the Elderly	Research Triangle Inst. Research Triangle Park, NC	$ 179,266
Developing an Index of Elder Abuse	Wayne State University Detroit, MI	$ 153,742
Development of a Professional Housing Management System to Support Improved Quality of Living for Older Americans	National Center for Housing Management Washington, DC	$ 25,017
A Model for Innovative Home Equity Conversion Through Linkages Between the Private and Public Sectors	Bureau of Maine's Elderly Augusta, ME	$ 150,771
Home-Made Pension Plans: Converting Home Equity Into Retirement Income	National Center for Home Equity Conversion Madison, WI	$ 118,500

APPENDIX VII

TITLE IV-B, DEMONSTRATIONS
FY 1982 Continuations

National Organizations

Title	Recipient	FY 1982 Funds
National Organization Projects Program	The National Center on Black Aged Washington, DC	$ 269,390
	National Indian Council on Aging Albuquerque, NM	$ 157,000
	National Pacific Asian Elderly Resource Center Special Service for Groups Los Angeles, CA	$ 199,953
	Asociacion Nacional Pro Personas Mayores Los Angeles, CA	$ 220,000
	National Association of Counties Washington, DC	$ 76,500
	National Council on Aging Washington, DC	$ 125,785
	Western Gerontological Society San Francisco, CA	$ 52,226
	United Neighborhood Centers of America New York, NY	$ 79,939
	U.S. Conference of Mayors Washington, DC	$ 119,927
	Urban Elderly Coalition Washington, DC	$ 14,000
NASUA National Aging Organization Project	National Association of State Units on Aging Washington, DC	$ 298,562

State Data Reporting Systems

Title	Recipient	FY 1982 Funds
Developing National Data Base	National Association of State Units on Aging Washington, DC	$ 278,000
Texas Management Information System Project	Texas Dept. of Aging	$ 18,094
Ohio Aging Services Information System	Ohio Commission on Aging	$ 84,515
An Integrated Statewide Information System for Aging Services in New York	New York State Office for the Aging	$ 84,928
Service Data Reporting System	Office of Senior Citizens Activity Jefferson County, Alabama	$ 75,000
Service Delivery Data Using the NSUA Taxonomy for Unit Cost Analysis	Florida State Department of Rehabilitation Services Aging and Adult Services Tallahasee, FL	$ 15,000

Services in Rural Areas

Title	Recipient	FY 1982 Funds
Community Support Systems for Rural Frail Elderly	Mon Valley Health and Welfare Council Monessem, PA	$ 62,996
Rural Western Wisconsin Service Delivery System	Area Agency on Aging, Inc., District V LaCrosse, WI	$ 83,000
Rural Day Care for Elders	Illinois Dept. on Aging Springfield, IL	$ 42,000
Focus on Elderly Health and Social Services for Rural Elderly	Gateway Area Development District Owingsville, KY	$ 43,933
Rural Aging Services Project	New York State Office Aging Albany, NY	$ 60,000

Elderly Abuse

Title	Recipient	FY 1982 Funds
Massachusetts Elder Abuse Project	Massachusetts Dept. of Elder Affairs	$ 105,000
Demonstration Project on Elderly Abuse	Metropolitan Commission on Aging of Syracuse and Onondaga County, NY	$ 66,000
Elder Abuse Program	Rhode Island Dept. of Elderly Affairs	$ 54,489

Enhancement of Services to Migrants, Refugees, and Immigrants

Title	Recipient	FY 1982 Funds
Pacific Asian Elderly Service Development Project	Seattle King County Division on Aging Seattle, WA	$ 100,000
Model to Provide Medical Care and Social Services for Immigrant Elderly	Denver Regional Council of Governments	$ 53,770

Enhancement of Services to Minorities

Title	Recipient	FY 1982 Funds
Minority Service Enhancement Project	New York City Dept. of for Aging New York, NY	$ 72,000
Centro de Los Ancianos	Area Agency on Aging, Region I Phoenix, AZ	$ 70,000
Prototype for Area Agency on Aging to Enhance Services to Elderly	Area Agency County of San Diego San Diego, CA	$ 99,000
Alternative Models for Operating Comprehensive, Coordinated Services to Elderly on Indian Reservations	Intertribal Council of Arizona Phoenix, AZ	$ 49,000

Legal and Ombudsman Services

Title	Recipient	FY 1982 Funds
Legal Services/ Ombudsman Services	Grants to Individual States	$2,852,000
	FY 1982 New Projects	
	Mental Health	
Expanding Mental Health Services for the Elderly	Dept. of Health and and Social Services Madison, WI	$ 99,883
Building Ties to the Mental Health System: The Aging Network's Role	Office of Services to the Aging Lansing, MI	$ 102,500
	Public Policy Options	
Church Based Human Services Network	The Psychological Center Fuller Theological Seminary Pasadena, CA	$ 45,149
Non-Services Approaches to Problems of the Aged	SRI International Menlo Park, CA	$ 95,000
Human Services Innovations Projects	SRI International Menlo Park, CA	$ 85,500
	Management	
Local and Area-Wide Information Systems	North Charles Mental Health Research and Training Foundation Cambridge, MA	$ 112,799
State Agendas for Alternative Action	Council of State Planning Agencies Washington, DC	$ 103,252
Management Indicators for Human Service Programs	National Association of State Units on Aging Washington, DC	$ 345,760

Title	Recipient	FY 1982 Funds
	Housing	
Ownership Transfer Project	New York City Dept. of Human Preservation and Development	$ 89,933
	Volunteerism	
Volunteerism and the Rural Aging American	Suomi College Hancock, MI	$ 160,450
The Volunteerism Project	Community Council, Inc. Phoenix, AZ	$ 50,340
	Health and Safety	
Background on Accidental Hypothermia and the Older Adult	Center for Environmental Physiology Washington, DC	$ 7,500
Heat Stress and the Older Adult	Center for Environmental Physiology Washington, DC	$ 9,975
Senior Citizen Fire Safety Education	New York City Fire Department New York, NY	$ 140,520
	Legal and Ombudsman Services	
Corporate Council Initiative	American Bar Association Washington, DC	$ 72,700
Model System of Guardianship and Protection	Protection and Advocacy Agency of Hawaii Honlulu, HI	$ 120,799
TA Manual, LTC Ombudsman Program	Robert Wainess Washington,DC	$ 9,981

Intergenerational

Title	Recipient	FY 1982 Funds
Utilization of Retired Senior Citizens as Child Day Care Providers	Governor's Commission for Children and Youth Jackson, MS	$ 13,700

Community Services

Title	Recipient	FY 1982 Funds
Wisconsin System Initiative for Long-Term Support	Wisconsin Dept. of Health and Social Services Madison, WI	$ 200,000
Study of Wisconsin Community Options Program	Wisconsin Dept. of Health and Social Services Madison, WI	$ 128,281
Linking the Social Services and the Civil Justice System	National Center for State Courts Williamsburg, VA	$ 143,701

Disaster Assistance

Title	Recipient	FY 1982 Funds
Disaster Assistance	Grants to Individual States in Regions I, V and IX	$ 81,500

Science and Technology

Title	Recipient	FY 1982 Funds
Use of Business Volunteers to Help State and Area Agencies on Aging	Union Carbide Retiree Service Corp New York, NY	$ 100,000
Technical Volunteer Service Retired	New England Innovation Group Providence, RI	$ 80,000
Technology Commercialization for the Aging	Mar-Tech Washington, DC	$ 125,000

APPENDIX VIII

LONG-TERM CARE PROJECTS

Long-Term Care Channeling Demonstration Program

Title	Recipient	FY 1982 Funds
Evaluation of the Channeling Demonstrations	Mathematica Policy Research, Inc.	$3,200,000*

Long-Term Care Gerontology Centers

The Southeastern New England Long-Term Care Gerontology Center	Brown University Providence, RI	$ 573,344
Center for Geriatics and Gerontology/Long-Term Care	Columbia University New York, NY	$ 573,695
UCLA/USC Long-Term Care Gerontology Center	UCLA Los Angeles, CA	$ 573,521
Suncoast Gerontology Center for Health and Long-Term Care	University of South Florida Tampa, FL	$ 573,698
Pacific Northwest Long-Term Care Center	University of Washington Seattle, WA	$ 573,553
Long-Term Care Gerontology Planning Grant	University of Utah Salt Lake City, UT	$ 99,201
Long-Term Care Gerontology Planning Grant	University of Oklahoma Oklahoma City, OK	$ 97,513
Long-Term Care Gerontology Planning Grant	University of Texas Dallas, TX	$ 97,301

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*These monies are Title III Evaluation funds.

Long-Term Care Gerontology Centers (cont.)

Title	Recipient	FY 1982 Funds
To Facilitate Information Exchange and Organizational Development Among LTC Gerontology Centers	Association of America Medical Colleges Washington, DC	$ 101,948

LTC Research and Demonstration Projects

Title	Recipient	FY 1982 Funds
Caregiver Support Initiative	Dept. of Health and and Social Services Bureau of Aging Madison, WI	$ 99,022
Family Supports: A Preventive Approach	Pacific Northwest Long-Term Care Center Seattle, WA	$ 133,053
Adult Residential Day Care Demonstration Project	Mountain States Health Corporation Boise, ID	$ 171,245
Parent-Caring: A Training Program Families and Professionals	College of Scholastica Duluth, MN	$ 63,737
Developing a Family Centered Approach To Aging: Orienting a Rural Community	Mifflin-Juaniata Area Agency on Aging, Inc. Lewistown, PA	$ 15,410

Long-Term Care Policy Analysis

Title	Recipient	FY 1982 Funds
Developing and Communicating Knowledge on Long-Term Care to Targeted Audiences	National Conference on Social Welfare Washington, DC	$ 15,000

Geriatric Fellowship Program

Recipient	FY 1982 Funds
Mt. Zion Hospital and Medical Center University of California San Francisco, CA	$ 60,267
UCLA School of Medicine Los Angeles, CA	$ 77,500
Harvard Medical School Boston, MA	$ 77,500
University of Washington School of Medicine Seattle, WA	$ 76,745
Duke University Center for the Study of Aging and Human Development Durham, NC	$ 77,500
Boston University School of Medicine Boston, MA	$ 75,024

ADMINISTRATION FOR NATIVE AMERICANS

ACTIVITIES ON AGING

The Administration for Native Americans (ANA) promotes economic and social self-sufficiency among American Indians, Alaska Natives and Native Hawaiians throughout the United States. The ANA mission is carried out through policies supportive of the Federal policy of Indian self-determination with respect to federally-recognized tribes which are units of government within the Federal system. The emphasis for other Native American groups is on fostering local control and decision-making as a means of improving service delivery and enhancing economic progress.

ANA's role as lead agency within the Department of Health and Human Services (HHS) on issues concerning Native Americans enables participation through interagency agreements in an effort to not only leverage dollars, but also to impact on various segments and issues in the Native American population. For example, in recognition of the signification role that American Indian elders have traditionally held in their communities, as well as their present influence in transmitting and assuring cultural continuity, a joint effort was engaged in to address some problem areas of American Indian elders. The result was the American Indian Elders Initiative signed on October 5, 1982 between the Commissioners of the Administration on Aging (AOA), the Administration on Developmental Disabilities (ADD) and the Administration for Native Americans (ANA). The purposes of this initiative are to (a) improve coordination of program efforts that enhance or extend services to more individuals without an increase in cost to individual agencies; and (b) effect measurable, positive impact on income security, health care, and access to services for Indian older persons.

Another initiative arose out of a concern that over the years an increase in Federal programs on reservations has resulted in an increase in the administrative burden imposed on tribal governments. Consequently much of the time and effort which should be spent in providing services at the local level is diverted to the administrative requirements of managing Federal grants. In addition, the fragmented nature of multiple Federal funding sources makes it difficult for tribes to coordinate services locally. The Human Development Services (HDS) Cooperative Management Initiative was established to improve the management of the HDS Indian programs—ANA, the Administration for Children, Youth and Families' Indian Head Start program, and the AoA Nutrition and Social Services for the Indian Elderly (title IV of the Older Americans Act). The effort is expected to facilitate tribal efforts, to develop centralized planning, coordinate programs at the local level and promote more cost-effective use of limited tribal resources. Reduced administrative costs at the local level are anticipated.

In a more direct manner, ANA for the last 3 years has provided financial assistance to the National Council on Aging (NICOA) through an interagency agreement with AoA. The original NICOA focus was the provision of training and technical assistance (T/TA) to American Indians on and off-reservation and Alaskan Natives in an effort to identify entitlement services available to them and to assist them in attaining access to those services. Today NICOA's efforts go beyond dissemination of information activities, provision of technical expertise to forums such as the White House Conference on Aging and T/TA activities to the establishment of an Indian elderly network, advocacy activities such as support for a policy statement for Indian elderly, creation of an access survey and model development project and support for the development of Indian councils on aging within each State as a necessary complement to groups at the local and national level.

TITLE XX

The Office of Human Development Services is responsible for administering the social services block grant program under title XX of the Social Security Act in the 50 States, the District of Columbia, and in four territories—Puerto Rico, the Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands. Formerly a categorical grant program, title XX was amended by the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) to establish the social services block grant (SSBG) program, effective October 1, 1981.

Under the SSBG, States and other jurisdictions receive funds to deliver services based on the needs of the citizens of the State. Within the limitations in the law, States have substantial discretion to determine what services to provide, who will be eligible for those services and how the services will be provided, i.e., by State agency staff or through purchase or other arrangements with private or other public agencies and organizations.

Unlike the previous title XX program, States are *not* required to: (1) Provide at least 3 services to SSI recipients; (2) develop comprehensive services plans which contain specific data and detailed information regarding services and recipients of services; (3) provide State (matching) funds; (4) have eligibility requirements based on income; and (5) observe detailed and specific procedures for obtaining public comment on the State's services program.

Under the SSBG program, States must develop a pre-expenditure report containing information on the intended use of the funds, including the types of activities to be supported and the categories and characteristics of individuals to be served; make it available for public comment; and submit it to the Department. Every 2 years, States must prepare a report to the public and to the Department on how the block grant funds were spent. They must also audit their expenditures every 2 years and make the audit report available to the State legislature and the Department.

The State pre-expenditure reports for fiscal year 1982 (the first year of operation of the SSBG) do not contain enough data to provide national totals on numbers of recipients, categories of recipients (e.g., the elderly) or specific service expenditures. Most of the services identified were similar, if not identical, to services provided under title XX in previous years. For example, with respect to assisting older persons to attain or maintain self-care and independence, all States provided "home-based services" which could include services such as chore services, homemaker services, home management services, and home-health related services; most States provided protective services and day care for adults; and at least half of the States provided transportation and home delivered and/or congregate meals services. Other services in the fiscal year 1982 pre-expenditure reports that could be used by older persons included legal services, housing improvement, and assistance with deinstitutionalization and institutional placement.

Research and demonstration projects in the past few years utilizing title XX funds have focused on improved service delivery (e.g., protective services for adults, transportation) and management techniques (e.g., accounting, case management, application systems). For a discussion of other HDS Funded research and demonstration projects directed towards older persons, see the discussion on the Administration on Native Americans (HDS) and the Administration on Aging (HDS).

SOCIAL SECURITY ADMINISTRATION

PROGAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers the Federal old-age, survivors, and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic program in the United States that assures income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay earmarked social security contributions (FICA taxes); the self-employed also contribute a percentage of their net earnings. Then, when earnings stop, or are reduced because of retirement in old-age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Current contributions are largely paid out in current benefits. However, at the same time, current workers build rights to future benefit protection.

SSA also administers the supplemental secuity income (SSI) program for aged, blind, and disabled people in financial need (title XVI of the Social Security Act). SSI provides a federally financed floor on income for eligible individuals with limited income and resources. In most cases, SSI supplements income from other sources including social security benefits.

The low-income home energy assistance program, which provides grants to States to help low-income households offset the rising costs of home energy, is also administered by the Social Security Administration.

SSA shares responsibility for the black lung program with the Department of Labor; SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for those benefits prior to July 1973, and for payment of black lung benefits to certain survivors of miners.

Local Social Security offices process applications for entitlement to the medicare program and assist individuals in filing claims for medicare benefits. Overall Federal administrative responsibility for the medicare program rests with the Health Care Financing Administration.

Following is a summary of beneficiary levels, selected administrative activities, study groups, court decisions, and social security-related legislation enacted in fiscal year 1982.

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1982, about 94 percent of all Americans age 65 and over were drawing social security benefits, or were eligible to draw benefits if they or their spouses retired; about 95 percent of the people who reached 65 in 1982 were eligible for benefits. It is expected that 96 percent of the aged will be eligible for social security benefits by the end of the century.

At the end of September 1982, 35.6 million people were receiving monthly social security cash benefits compared to 35.8 million in September 1981. Of these beneficiaries, 20.6 million were retired workers, 3.6 million were dependents of retired workers, 65,700 were uninsured individuals receiving "special age-72" (Prouty) benefits, 4.1 million were disabled workers and their dependents, and 7.3 million were survivors of deceased workers.

The monthly amount of benefits paid for September 1982 was $13.2 billion, compared to $12.1 billion for September 1981. Of this amount, $9.3 billion was paid to retired workers and their dependents, $1.3 billion was paid to disabled workers and their dependents, $2.5 billion was paid to survivors, and $8 million was paid to special age-72 beneficiaries.

Retired workers received an average benefit for September 1982 to $417 (up from $384 in September 1981), while disabled workers received an average benefit of $442 (up from $414). Retired workers newly awarded social security benefits for September 1982 averaged $409, while disabled workers received an average initial benefit of $441. During fiscal year 1982 (October 1981 to September 1982), an estimated $152 billion in social security cash benefits were paid, compared to $136 billion in fiscal year 1981. Of that total, retired workers and their dependents received an estimated $101.3 billion, disabled workers and their dependents received an estimated $17.4 billion, survivors received an estimated $33 billion, and special age-72 beneficiaries received an estmated $102 million. In addition, lump-sum death payments amounted to an estimated $210 million.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In 1982, SSI payment levels (like social security benefit amounts) were automatically adjusted to reflect a 7.4-percent increase in the Consumer Price Index (CPI). Thus, beginning in July 1982, maximum monthly Federal SSI payment levels increased from $264.70 to $284.30 for an individual, and from $397 to $426.40 for a couple. (These benefits are financed from general revenues.)

During fiscal year 1982, about $8.6 billion in benefits (consisting of $6.8 billion in Federal funds and $1.8 billion in federally administered State supplements) were paid. Of 3.9 million beneficiaries on the rolls during September 1982, nearly 1.6 million were aged, and 2.3 million were receiving SSI based on blindness and disability, although 453,000 of them reached age 65 after they began to get payments. During September 1982, total payments of $774 million were made. The total payments in fiscal year 1982 represent an increase of about $0.4 billion over fiscal year 1981.

III. LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

Beginning in October 1980, SSA was given Federal administrative responsibility for a program of low-income home energy assistance. The purpose of the program is to help low-income households avoid serious health and financial crisis by providing them assistance to meet the rapidly rising cost of home energy. Congress authorized, in the Omnibus Budget Reconciliation Act of 1981, $1.875 billion annually for the Low Income Home Energy Assistance Act for fiscal years 1982 through 1984. Block grants are made to States, territories, and eligible applicant Indian tribes. States, territories, and tribes may provide heating, cooling, and crisis intervention assistance and low-cost weatherization or energy-related home repair to income eligible households. Grantees can make payments to households with incomes within 150 percent of OMB proverty guidelines, or within 60 percent of the State median income, or to households which contain an individual who receives supplemental security income, food stamps, aid to families with dependent children, nor needs-tested veterans' benefits.

In fiscal year 1981, approximately one-third of all households which received energy assistance contained a person age 60 or over; almost all States used age 60 for their eligibility standard for people who did not qualify because of entitlement to another assistance program, such as SSI. Based on preliminary reports, the percentage was approximately the same for fiscal year 1982.

IV. BLACK LUNG BENEFITS AND BENEFICIARIES

Although responsibility for new black lung miner claims shifted to the Department of Labor in July 1973, SSA continues to pay black lung benefits to a significant, but gradually declining, number of miners and survivors.[1] During September 1982, about 359,000 individuals (215,000 age 65 or older) received $88.3 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 104,000 miners received $44.3 million, while 145,000 widows received $44 million. About 90,000 of the miners and 125,000 of the widows were age 65 or older. The miners and widows had 110,000 dependents. During fiscal year 1982, SSA administered black lung payments in the amount of $1.1 billion.

Black lung benefits increased by 4 percent in October 1982 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased to $305 from $293. The monthly benefit for a miner or widow with one dependent if $457 and with two dependents is $534. The maximum monthly benefit payable when there are three or more dependents is $610.

V. SECRETARY'S TASK FORCE ON SERVICE DELIVERY IMPROVEMENTS TO THE ELDERLY

SSA is contributing to a task force established on the recommendation of the 1982 White House Conference on Aging seeking to improve service delivery to the elderly. This task force is chaired by the Assistant Secretary for Human Development Services; its final report is due mid-1983.

VI. IMPROVED COMMUNICATION AND SERVICES

Notices to Beneficiaries

A continuing effort is being made to simplify manual and computer-generated notices so that beneficiaries can better understand them.

A 3-year schedule for redesigning all of SAA's post-entitlement notices has been established. Work is underway now on automating one of SSA's high-volume notice systems as the first step in this schedule.

Amendment Information

A wide variety of informational materials was produced in connection with changes under Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, and Public Law 97-123, Restoration of the Social Security Minimum Benefit and Other Changes. The informational material, including news releases, radio spot announcements, leaflets, and direct mailings on individual amendments, and some 2 million copies of a comprehensive amendment leaflet, explained how these laws changing the social security programs affected people.

Coverage of State and Local and Nonprofit Employees

About 9.4 million employees of State and local governments are covered under social security. Approximately 5.1 million employees of nonprofit organizations are covered. In recent years, more State and local entities have considered terminating coverage because of rising social security costs. SSA is active in informing groups of the consequences of possible termination. It tries to insure that the employees affected know of the comprehensive protection social security affords. As a result of SSA's efforts, 16 State and local entities scheduled to terminate coverage at the end of 1982 (representing 7,600 employees) had cancelled their notices as of September 30, 1982. Also, 36 nonprofit hospitals with 35,000 employees, and 17 other nonprofit organizations had cancelled their termination notices. We expect many other State, local, and nonprofit organizations will do so before their actual termination dates are reached.

As of September 30, 1982, 487 State and local entities with about 243,000 employees were pending termination. Pending terminations for nonprofit employers number 955, representing 417,000 employees.

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[1] While DOL administers new claims under part C of the Federal Coal Mine Safety and Health Act, SSA is still responsible for administering part B of the act.

The Social Security Administration during 1982 developed a variety of printed and audiovisual materials to inform employers and employees about the effect of termination. These included a kit of materials summarizing the arguments against termination and highlighting the advantages of remaining with social security, and a videotape discussion of the consequences of termination.

Another effort we are undertaking on termination activities is liason with national organizations. Regular contacts are made with representatives of the National Conference of Social Security Administrators, the Service Employees International Union, the National Education Association, and other umbrella organizations to exchange information affecting the termination issue. Liaison has also been established with the American Hospital Association, the American Nurses Association, and the National Catholic Conference. These organizations are now cooperating in disseminating information on the value of social security to their members.

National Year of Disabled Persons

The United Nations declared 1981 as the International Year of Disabled Persons (IYDP). During the year, SSA carried out an active program to make its field offices more accessible and to enhance career opportunities for handicapped employees. Realizing that more can be done, SSA is continuing its IYDP-related initiatives through fiscal year 1983. Efforts will be directed toward removal of architectural barriers and the improvement of services to such groups as the blind and hearing-impaired. These activities are of interest to older people also, because 69 percent of disabled social security beneficiaries are age 50 or older.

VII. SSA ADMINISTRATIVE GOALS AND ACCOMPLISHMENTS

During fiscal year 1982, SSA placed major emphasis on improving the performance of its systems, the fiscal integrity of its payments, improving the administration of the disability insurance program, and continuing to improve beneficiary services.

A 5-year systems modernization plan was developed this year. This plan will completely reengineer SSA's systems in two phases. The first phase, initiated in 1982, concentrates on improving systems performance in the short term; the second phase, to be initiated by the end of 1983, will ultimately bring SSA's archaic systems capability up to modern systems technology.

Measures taken in 1982 to improve the fiscal integrity of program payments included better and earlier identification of overpayments made and improved procedures for arranging for collection or waiver of overpayments.

During fiscal year 1982, SSA took steps toward improving the administration of the disability insurance program by: Instituting a number of management initiatives in the continuing disability process, strengthening management of medical examinations and tests purchased at Federal expense, and enhancing State agency processing time and accuracy.

VIII. NATIONAL COMMISSION ON SOCIAL SECURITY REFORM

The National Commission on Social Security Reform was established by President Reagan in December 1981, to identify solutions to the social security financing problems that will assure both the financial integrity of the system and the provision of appropriate benefits. The President, the Majority Leader of the Senate, and the Speaker of the House of Representatives each selected five members of the 15-member Commission. The goals of the Commission are: (1) To propose realistic, long-term reforms to put social security back on a sound financial footing, and (2) to forge a working, bipartisan consensus so that the necessary reforms can be passed into law. The Commission, which met in public sessions throughout 1982, reported its analysis and recommendations to the President, the Congress, and the Secretary of Health and Human Services on January 20, 1983.

IX. PRECEDENT-SETTING COURT DECISIONS THAT AFFECT THE ELDERLY MADE DURING FISCAL YEAR 1982

Government Pension Offset Provision

The government pension offset provision has continued to be the subject of significant litigation. Under this provision, a person's social security spouse's benefit is reduced by the amount of any pension he or she may receive based on his or her own work in government employment not covered by social security. The provision contains an exception clause allowing people who were eligible for their government pensions before December 1, 1982, to receive full social security spouse's benefits if they can meet the eligibility criteria under the law as administered by SSA in January 1977. Since, under the rules in 1977, a husband had to receive one-half support from his wife in order to be eligible for a spouse's benefit, most men cannot qualify for the exception and cannot receive full social security spouse's benefits.

On August 24, 1982, a U.S. district court decision (*Mathews et al.* v. *Schweiker*) held that the exception to the pension offset is unconstitutional because it has the effect of continuing the one-half support test, which applied only to males and which was found to be unconstitutional by the Supreme Court. The district court also declared unconstitutional the separability clause enacted as part of the exception. (Congress, in anticipation of a constitutional challenge, had legislated that, should the exception be found unconstitutional, the offset would become immediately effective for everyone without exception.) The effect of the court's striking down both the exception and the separability clause would be to require SSA to pay full husband's benefit to all members of the class.

On October 12, 1982, the district court granted the government's motion for a stay of the court order in this case, and the Department of Justice has appealed this decision to the Supreme Court.

Yamasaki-Title II—Personal Conferences

In June 1979, the U.S. Supreme Court ruled in *Yamasaki* that SSA must provide a title II beneficiary with an opportunity for a prerecoupment personal conference before a request for waiver of an outstanding overpayment can be denied. SSA and plaintiffs' attorneys differ in the interpretation of the Supreme Court's decision. SSA has interpreted the court decison as requiring SSA to provide an individual an opportunity for a personal conference. The plaintiffs' attorneys view *Yamasaki* as requiring SSA to automatically schedule a personal conference in every case. Two district courts have ruled in favor of the plaintiffs' interpretation of *Yamasaki*. At the direction of the court, procedures implementing automatic scheduling of a conference have been ordered in the State of Hawaii.

In June 1982, the Circuit Court of Appeals upheld the district court and held that SSA is required to automatically schedule a personal conference. SSA has recommended seeking Supreme Court review of *Yamasaki*.

In July 1981, the district court (Washington) in *Buffington* ruled similarly to *Yamasaki* and held that SSA must automatically schedule a personal conference. *Buffington* represents the nationwide class on the issue. No final order on *Buffington* has been issued.

Soberal-Perez—Spanish Language Services

In *Soberal-Perez*, the district court ruled in favor of the Secretary on October 19, 1982, and held that decisions of whether notices *must* be provided in a language other than English "must be made through the democratic process, not by order of a Federal court." In addition, the court stated that the historical basis and modern rationale "for conducting governmental affairs in English is clear: The national language of the United States is English." In providing rationale as to why the Government's mechanisms for notifying claimants is not discriminatory, the court stated that the governmental practices serve a legitimate governmental purpose and that the procedures are not irrational. The court concluded by finding that the cost in time, money, and administrative disruption are sufficient justification for the current governmental practices. Accordingly, in addition to dismissing the civil action, the court did not certify a class action.

The plaintiffs had challenged the constitutionality of the use of English notices by SSA and the alleged failure of SSA to staff its district/branch offices with a sufficient number of Spanish-speaking employees. The plaintiffs alleged that, because of SSA's failure to provide Spanish language services, Spanish-speaking applicants/recipients were denied equal access to the benefit programs administered by SSA. In a ruling favorable to the Secretary, the judge noted that SSA had taken initiatives to voluntarily provide certain services to the Hispanic community.

Separated Couples in SSI

The U.S. Supreme Court denied plaintiff's petition for a writ of certiorari in *Johnson* v. *Schweiker*, leaving the decision of the U.S. Circuit Court of Appeals for the Ninth Circuit to stand. The ninth circuit upheld the decision of the U.S. District Court for the Northern District of California and ruled in February 1982 that SSA's regulations were valid. These regulations do not provide for a determination of the actual availability of unearned income to plaintiff Johnson in calculating her SSI benefits during the first 6 months of her separation from her husband. Under the law, members of an SSI eligible couple who separate are not treated as two eligible individuals (with a higher Federal benefit rate) until after they have been separated for 6 months. All the income and resources of an eligible couple are treated as belonging equally to the couple for this 6-month period. Mrs. Johnson protested that her estranged husband's income should not affect her SSI benefit during this separation. The courts unanimously disagreed and supported SSA's interpretation of the Social Security Act.

X. SUMMARY OF LEGISLATION ENACTED IN FISCAL YEAR 1982 THAT SIGNIFICANTLY AFFECTS SSA

Public Law 97-123 (H.R. 4331), Restoration of the Social Security Minimum Benefit and Other Changes—Signed on December 29, 1981

This law changed the minimum benefit provisions of Public Law 97-35 (August 13, 1981), to restore the minimum benefit for current beneficiaries and eliminate the minimum benefit for new beneficiaries (people who reach age 62, die, or become disabled after 1981). Entitlement to the minimum benefit would be retained for those eligible after 1981 and before 1992 who are members of a religious order under a vow-of-poverty which elected to be covered under social security before December 29, 1981. Other provisions include: Permit interfund borrowing among the old-age and survivors insurance, disability insurance, and hospital insurance trust funds through December 31, 1982; extend the social security payroll tax to the first 6 months of sick pay (including payments by insurance companies, State temporary disability insurance laws, and the railroad temporary disability insurance program); increase maximum penalties for misuse of social security numbers; require that the Secretary of Health and Human Services report by March 29, 1982, on the most effective system for improving SSA's current "report of death" procedures; and require agencies of the U.S. Government or any State to disclose information necessary to carry out the provisions relating to the prohibition of payments to prisoners.

Public Law 97-248 (H.R. 4961), the Tax Equity and Fiscal Responsibility Act of 1982—Signed on September 3, 1982

Makes the following changes in provisions directly or indirectly affecting the old-age survivors disability insurance (OASDI) and supplemental security income (SSI) programs:

Directly affect the supplemental security income program

Effective date of application; proration of initial SSI benefit payment.—Provides that an application will be effective on the date of filing or, if later, the date upon which the individual becomes eligible for SSI. The SSI benefit for the first month of eligibility will be prorated by the number of days in the month for which there is an effective application. The SSI benefit also will be prorated from the date eligibility conditions are met in the first month following a month of ineligibility.

Rounding of SSI eligibility and benefit amounts.—Provides that the SSI monthly benefit and income eligibility amounts, if not in whole dollars, will be rounded to the next lower whole dollar amounts after the annual cost-of-living adjustment (COLA) is calculated. Subsequent benefit and eligibility standard increases due to annual cost-of-living adjustments will be based on the SSI standard that resulted before the previous year's amount was rounded downward.

Coordination of SSI and OASDI cost-of-living adjustments.—As an exception to retrospective accounting, the amendment provides that increases in OASDI benefits, including the OASDI COLA, in the month that an SSI COLA becomes effective and in the following month will be taken into account as income in such month and in the following month.

Also provides that other changes in income and relevant circumstances may, at the Secretary's option, be taken into account in the month that the change is expected if there is reliable information available concerning the change.

Phaseout of hold-harmless protection.—Provides for the continued phaseout, over a 3-year period (fiscal year 1982-84), of Federal contributions toward the cost of States' supplementary payments.

Exclusion from resources of burial plots and certain funds set aside for burial expenses.—Provides for the exclusion of burial spaces for the use of an individual and members of his or her immediate family. Also provides for the exclusion of up to $1,500 each for an individual and spouse held in separately identifiable burial funds.

The Secretary is authorized to exclude from income and resources increases in the value of burial funds which result from accrual of interest or from appreciation.

Indirectly affect the OASDHI and SSI programs

Medicare coverage for Federal employees.—Provides that Federal employment now excluded from social security coverage will be subject to the hospital insurance (HI) portion of employer and employee social security taxes effective January 1, 1983. Federal employees will earn quarters of coverage for determining entitlement to medicare hospital insurance in the same manner as other employees earn regular quarters of coverage for the OASDHI programs.

Treatment of real estate agents and direct sellers.—Effective for services performed after 1982, salespersons who are licensed real estate agents, and individuals who are direct sellers, will be treated for Federal income and social security tax purposes as self-employed persons where certain conditions are met.

Independent contractors.—Provides for an indefinite extension of the interim provisions first enacted as part of the Revenue Act of 1978 under which taxpayers who had a reasonable basis for not treating workers as employees in the past could continue to do so without incurring Federal social security and unemployment compensation tax liabilities. The interim provisions also prohibit the Treasury Department from issuing any regulations or revenue ruling that classifies individuals as employees or self-employed for purposes of such taxes under common law.

Reduction of certain employment tax liabilities where workers are reclassified as employees.—Provides tax relief for employers in certain cases where a worker is reclassified from an independent contractor to an employee and the employer failed to withhold income taxes or social security taxes from the worker's earnings.

Relief for the Jefferson County Mental Health Center, Lakewood, Colo.—Requires the Secretary of the Treasury to pay $50,000 in full settlement for claims of the center against the United States for repayment of social security employee taxes that the center erroneously refunded to its employees pursuant to instructions from the Internal Revenue Service.

Reporting of tips.—The purpose of the provision is to facilitate the examination of income tax returns filed by tipped employees. The provision does not change the law with regard to reporting of tips to employers by employees and the withholding of social security taxes on those tips by employers.

Public Law 97-253 (H.R. 6955), the Omnibus Reconciliation Act of 1982—Signed on September 8, 1982

Contains civil service-, veterans-, and food stamp-related provisions which will indirectly affect social security because of the interrelationships of payments under these programs, as follows:

Creditable service based on military service and recomputation at age 62 of credit for military service of current annuitants

Provides that in order for a current or new Federal employee or his or her survivor (as added by Public Law 97-346, October 15, 1982) to have post-1956 military service counted for civil service retirement purposes after age 62, amounts equal to civil service retirement (CRS) contributions on the military wages must be deposited to the CSR fund. The changes would not affect the present coverage of post-1956 military service under the social security program.

Current retirees (who are retired under the CSR system on or before October 1, 1982) would have their CSR annuity recomputed to restore credit for their post-1956 military service. The CSR annuity would then be reduced by an amount equal to the proportion of the social security benefit that is attributable to the military earnings.

Disclosure of social security information in connection with the civil service disability retirement system

Authorizes the Director of the Office of Personnel Management to receive information in the Social Security Administration's records for purposes of administering the civil service disability retirement program.

Coordination of food stamp cost-of-living increases

Excludes from income, for food stamp program purposes, amounts paid in July through September of each year that are attributable to cost-of-living adjustments in OASDI, SSI, railroad retirement, and veterans' benefits. This exclusion applies only if the household was eligible for food stamps in the month before such adjustments.

Civil service retirement cost-of-living adjustment

Delays for 1 month in each year, 1983-85, the payment of cost-of-living adjustments in civil service retirement benefits (and in other benefits, such as those under the military retirement system and the Foreign Service retirement system, that are linked by law to the civil service adjustment). Thus, the month of adjustment will shift from April to May in 1983, June in 1984, and July in 1985.

HEALTH CARE FINANCING ADMINISTRATION

LONG-TERM CARE RESEARCH AND DEMONSTRATIONS

INTRODUCTION

Because the Health Care Financing Administration (HCFA) is the primary source of funding for long-term care services in the United States, it has an inherent interest in seeking alternative approaches to the delivery and financing of this care. The medicaid program is the principal payor of long-term care services, with Federal and State payments in fiscal year 1981 of approximately $11.5 billion for skilled nursing and intermediate care facility services and an estimated $428 million for home health services. That same fiscal year, the medicare program spent approximately $404 million for skilled nursing facility services and $939 million for home health services.[1]

The population at risk of long-term care services is small but growing. In 1980, about one out of nine persons was 65 and over. However, in the next 50 years, nearly one in five persons will be elderly. Expressed in absolute terms, the 25.5 million elderly in 1980 will become 55 million in 2030.[2] Data also indicate that currently three-fourths of all nursing home residents are 75 and over, and more than one-third are 85 years and older.[3] However, the aged are only one segment of the long-term care population.

The adult disabled constitute a substantial element of the population with long-term care needs. Approximately 23 percent of the population over the age of 18 have at least some limitation in their physical functioning.[4]

Data have also reported which indicate that the number of adult disabled under age 65 who have severe impairment is equal to the number of impaired persons over 65 years of age.[5]

Still another segment of the long-term care population are the mentally retarded and developmentally disabled. Developmental disabilities are defined as those conditions attributable to mental retardation, cerebral palsy, epilepsy or other related conditions. Mental retardation is defined on the basis of IQ as well as adaptive behavior. Recent estimates set the number of mentally retarded persons of all ages in the United States at 6 million, of whom 670,000 are diagnosed as severely handicapped. Of the remaining developmentally disabled population, 580,000 are estimated to have cerebral palsy, 206,000 are epileptics, and 600,000 have other neurological disorders including muscular dystrophy and speech and hearing disorders.[6] Within this segment of the long-term care population alone, there are several levels of impairment, from the profoundly retarded who require total and constant care, to the moderately retarded who might be able to manage some personal tasks with supervision, to the mildly retarded, who are often able to care for themselves and hold jobs. This latter subgroup is often able to live in a sheltered environment or alone.[7]

The adult chronically mentally ill make up another growing portion of the long-term care population. Mental disorders affect up to 15 percent of the population in the United States during any given year.[8] The President's Commission on Mental

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[1] Unpublished data from the Office of Financial and Actuarial Analysis, HCFA.

[2] U.S. Bureau of the Census. Current Population Reports, Series P-20, No. 363. Population Profile of the United States: 1980. U.S. Govt. Print. Off., Washington, 1981. U.S. Bureau of the Census. Current Population Reports, Series P-25, No. 704. Projections of the Population of the United States: 1977 to 2050, U.S. Govt. Print. Off. Washington, 1977.

[3] Statistical Reports on Older Americans. Some Prospects for the Future Elderly Population. Administration on Aging, January 1978.

[4] National Long-Term Care Project: Final Report. University of Chicago Center for the Study of Welfare Policy, August 1980.

[5] Congressional Budget Office. Budget Issue Paper, Long Term Care for the Elderly and Disabled. February 1977.

[6] LaVor, Judith, Long Term Care: A Challenge to Service Systems, Long Term Care. Praeger, 1979.

[7] LaPorte and Rubin. Long Term Care. Praeger, 1979.

[8] Archives of General Psychiatry, v. 35, June 1978.

Health reports that the direct cost of mental health services in the mid-1970's exceeded $17 billion per year, representing 12 percent of total national health expenditures. In addition, the mentally ill have higher than average rates of physical illness, using medical services at almost twice the rate of the nonmentally ill population.[9] Primary diagnosis data from 1976 and 1977 reveal that 800,000 mentally ill people were residents in nursing homes during that time. This accounts for upwards of two-thirds of the total nusring home population.[10]

The terminally ill who require care for an extended period of time, such as persons suffering from certain terminal forms of cancer, also fall within the long-term care population.

It is generally agreed that there is some overlap between these groups in terms of their long-term care needs but little is known about their characteristics and how their needs intersect or how they might be unique. This raises the issue that is at the core of the policymaking dilemma in long-term care: The lack of a precise definition of long-term care in terms of the nature of what constitutes such care and who should receive it.

The distinguishing feature of the long-term care population has been described as the inability to carry out certain routine daily tasks. Under the current service delivery system, the severity of the condition, combined with personal characteristics such as age, income, living arrangements, and availability of an informal support system, are the factors which often arbitrarily provide answers to questions about the type of care received and who should receive it. However, it has become increasingly evident to all levels of government and to consumers, that these factors are interrelated. No single aspect—diagnoses, age, income, etc.—can easily be used to determine the need for one type of care or treatment over another.

A good deal of interest has recently been directed at the financial and human implications of an inadequate service delivery system and the resulting placement of patients in inappropriate levels of care, especially those who have been inappropriately placed in institutional settings. Various studies have indicated that anywhere from 15 to 50 percent of institutional residents could be better served at a lower level of care.[11] However, because of the multifaceted nature of the long-term care populations, as noted earlier, levels of care cannot be easily quantified or determined, regardless of whether the care is provided in an institutional setting or in the patient's home. The challenge has been to develop a delivery system that has the capacity to strike a balance between meeting dependency needs of the long-term care patient, while simultaneously avoiding cutting off opportunities for rehabilitation and independent living.[12]

During the past several years, public opinion and professional concern has been focused on the availability and appropriateness of community-based long-term care. Specific efforts have been directed at the organization and delivery of community-based long-term care services, their financing and reimbursement, control of quality and abuse, the definition of eligibility, and coordination of services.

A major generating force behind the increasing governmental interest in community-based care is the desire for a means of controlling escalating long-term care costs. Community-based care has been advanced as an economy measure: however, the cost-effectiveness of community "alternatives to institutionalization" have not yet been proven in the aggregate. True costs of delivering long-term care in the community have been difficult to measure of predict.[13] The costs per unit of service are only now becoming available, but from a public policy perspective, it may be equally important to learn the total (system) cost of caring for a given individual with certain characteristices over a period of time.

In determining the appropriate type and level of care for an individual, various value considerations come into play, not all of which are mutually compatible. For example, independence, self-determination, individualization and normalization may clash with the goals of equity, economy, right to treatment, protection from harm and the protection of society.[14] None of these factors are easily measured but from the consumer's and the general public's perception, they are the key determinants of whether or not long-term care is effective or responsive to their needs. In the final analysis, these factors may be as important as cost in developing a comprehensive long-term care strategy.

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[9] Analytical Review of the Literature, Mental Disorder and Primary Medical Care, Services D. No. 5, National Institutes of Mental Health, 1974.

[10] Wallack, Stanley. Services for the Chronically Mentally Ill: The Implications of Financing. Brandeis University Health Policy Consortium, 1979.

[11] For a discussion of these studies, see General Accounting Office, Entering a Nursing Home: Costly Implications for Medicaid and the Elderly. Report to the Congress of the United States, 1979.

[12] University of Chicago Center for the Study of Welfare Policy, 1980.

[13] Ibid.

[14] Ibid.

Many groups both in the private and public sector are investigating the implications of various issues for society and the health care system. The following material describes HCFA's research and demonstration activities in long-term care as they relate to the medicare and medicaid programs.

HCFA Research and Demonstration Efforts

HCFA's Office of Research and Demonstrations (ORD) conducts a program of research, demonstrations, and evaluations in long-term care, particularly as long-term care relates to the populations and services covered by medicare and medicaid. Within ORD, both the Office of Research and the Office of Demonstrations and Evaluations are involved in the area of long-term care. In general, long-term care *research* activities involve the use and analysis of existing data, either collected by survey or abstracted from other data sources. Long-term care research has focused primarily on describing and explaining the demand for long-term care and the basic economic underpinnings of the long-term care industry. In addition, considerable effort has been given to the development of a methodology to measure the quality of long-term care provided in different settings. The purpose of this research is to develop an understanding of long-term health care delivery, reimbursement and financing systems, in order to provide some direction for private and public policymaking, and to identify promising areas for demonstration activities.

ORD's long-term care *demonstrations* (experiments) require the development of a rigorous research design and, within the design, a specific intervention is introduced into a live situation with subsequent observation of the outcomes. Evaluation findings form the basis for future policy recommendations regarding the medicare and medicaid programs.

LONG-TERM CARE RESEARCH—OVERVIEW

The role of the ORD long-term care research program is to provide vital information on current and anticipated policy issues related to the goals of the Department of Health and Human Services. Most critical are those areas which will provide information about how to contain costs while fostering efficient utilization of the long-term care system. The research program includes congressionally mandated studies and research of fundamental issues which underlie a multiplicity of current and future policy questions.

HCFA's long-term care research program consists of both intramural and extramural dimensions. On the intramural research side, for example, ORD has recently reviewed several major issues of direct and basis importance to the long-term care system in the United States. The results of this study have recently been compiled and produced in a book entitled, "Long Term Care: Some Perspectives from Research and Demonstrations." This report is in the process of being printed.

The extramural research program is similarly orientd to provide policy makers the necessary data for enhancing policy formulation and program development. Three project areas are discused below.

I. Determinants of Utilization

Research activities are being supported to explore determinants of long-term care use. The five studies in this group include research on: (1) The demographic and epidemiologic factors affecting long-term care, (2) interrelationships among the elderly, their families, and other informal supports, and demand for long-term care services, and (3) interactions between noninstitutional and institutional long-term care services.

In the first area, Duke University is studying the health status of the U.S. population using a model of the natural history of important chronic diseases. This model, which integrates evidence from several sources (vital statistics, epidemiological studies, clinical fundings, and physiological models) will be used to produce distributions of chronic diseases. With more accurate estimates of the prevalence and incidence of chronic diseases, better estimates of health care costs, particularly those for long-term care services, can be derived. Results of this project are available on a continuing basis as projections of different chronic diseases are developed.

In the second area, three projects are investigating the interrelationships among the elderly, their families, and demand for long-term care services. A study conducted by the University of Michigan identified relationships between certain characteristics known at the time clients enter home health care and their utilization patterns and status of discharge. A key finding was that characteristics of a personal and familial nature had a weaker relationship to intensity of service than payment characteristics. The study was completed in early 1981, and the final report is available.

A study by Hunter College is examing the family caregiving system of the frail elderly. It documents the types of services the family provides and the social and economic impacts they experience in doing so. It identifies factors that strengthen or weaken the family system in providing care to the elderly and recommends methods of enhancing the family caregiving system which would sustain the elderly in the community and avoid more costly alternatives. Two major results of this study are that:

(1) The primary stress of caregiving results from the emotional stress of dealing with a frail elderly relative and the restrictions on the caregiver's time and freedom; and

(2) The most frequently requested service needs are in the area of transportation, homemakers, friendly visitors, and respite services.

A study being conducted by the Community Service Society is examining the effects of providing substantial ongoing home service programs to functionally disabled low-income adults. Issues being explored include:

(1) Whether those using home services will experience better solutions to problems of daily living.

(2) Whether availability of home services will diminish use of inpatient hospital services and long-term care institutions; and

(3) Whether home services will reduce but not eliminate family participation in care.

This study will be completed by late 1983.

In the third area a study is being conducted by the North Carolina Health Care Facilities Association in conjunction with the University of North Carolina Health Services Research Center. The results of this study will be available in late 1984. They are investigating nursing homes' involvement in the provision of home health care, nutritional services, and adult day care. Topics of interest include how nursing homes decide whether to provide noninstitutional long-term care services, and the impact of recent Federal and State policy changes, such as medicaid waivers for home and community services, and the State's preadmission screening program.

II. Components of Costs

Several projects investigate the components of long-term care costs. This research focuses on providing a better understanding of the variation in costs between different modes of long-term care services (e.g., nursing homes, home health) and between different providers of the same mode of long-term care. Three projects in this area are examining the relationships between costs and patient case mix, quality of care, and provider characteristics.

The University of Colorado has completed a study of public and private patients in a representative sample of nursing homes in Colorado. The key finding of this study is that case mix plays an important role in explaining variations in nursing home costs. Specifically, as much as 40 percent of the variation in nursing and total cost per patient day was accounted for by variations in case mix among facilities. These results were not dependent on any one set of case mix variables, since similar results emerged for several different sets of case mix measures. Quality of care, as measured in terms of "process' of care, accounted for only about 10 percent of the variation in cost per patient day, although several quality variables were found to be significantly and positively related to cost. In addition, the study found that while medicaid patients had less intensive case mix than nonmedicaid patients, in general they received higher quality of care. Finally, significant case mix, but not quality differences, existed between hospital-based and freestanding nursing homes. Freestanding facilities tended to treat a greater proportion of patients with psychosocial problems while hospital-based facilities had greater portions of patients with medically related problems. Findings from the Colorado study led the investigators to suggest that patient case mix be incorporated in nursing home reimbursement strategies. Since case mix is most directly related to patient care services, they suggest that reimbursement systems link case mix primarily to the patient care cost category (e.g., nursing costs).

A second study at the University of Colorado is investigating cost differences between nursing home and home health care provided in freestanding and hospital-based settings. Policy issues to be addressed in this 4-year study include the following: Do the higher costs of hospital-based facilities justify different treatment from freestanding units for reimbursement and regulatory purposes; and is home health care a cost-effective substitute for nursing home care for certain types of patients? Preliminary results are expected by late 1983. Final results will not be available until early 1985.

Another project at Yale University studied skilled nursing facilities in Connecticut and identified groups of nursing home pateints according to their resource consumption. These patient groups were based on combinations of health characteristics, such as assistance required in dressing and feeding, ambulation, and the need for monitoring of fluid intake-output. The establishment of specific patient groups was based on the extent to which groups were homogeneous in terms of nursing staff time required. The study tested various combinations of patient groups and found that for the sample of patients drawn from 36 Connecticut nursing homes nine resource utilization groups (RUG's) were capable of reducing the variation in nursing staff time by 37 percent. Findings from the study led the investigators to suggest that resource utilization groups can be useful in operationalizing patient characteristics in case-mix related reimbursement strategies.

III. Program Assessment Studies

Another group of research studies investigate specific aspects of medicare or medicaid long-term care policies. For example, two studies mandated by Public Law 96-499, the Omnibus Reconciliation Act of 1980, assess medicare home health coverage for respiratory therapy and registered dietitian services. These studies will be submitted to Congress during 1983. A third study mandated by Public Law 96-499 was submitted to Congress in July 1982. This study investigated the provision of skilled nursing facility (SNF) services under medicare and medicaid. It found that many State medicaid programs provide broader, longer term SNF benefits than does medicare. Medicare covers only a small part of the nursing home population for very short-term convalescent care. Administrative differences between the programs, especially in reimbursement methods, discourage facilities participation in medicare.

Other research on reimbursement policy includes a study at the Urban Institute that will analyze the costs of medicare SNF's and simulate alternative approaches to prospective payment for medicare SNF's. They will also invesitgate administrative factors that affect the efficiency of patient-related rate payment systems used by the medicaid programs in several States.

Three projects assess the impact of State and Federal policies on long-term care utilization. The University of California, San Francisco, is examining the impact of State discretionary policies on the availability and utilization of long-term care, as well as the policy effects on the total cost and distribution of Federal, State, and local expenditures. This project will be completed in late 1983. A second study by Rhode Island Health Services Research examined the impact of Rhode Island's patient review system on nursing home utilization between 1973 and 1980. The study found that while the patient medical reviews resulted in more appropriate assignment of patients to the different levels of care according to their needs, these reviews had no impact on achieving deinstututionalization of patients who might be better served in a community setting. In the third study, Virginia Commonwealth University is assessing the State of Virginia long-term care screening program. Preliminary results, for the 18-month study period, suggest that the screening program reduced medicaid expenditures with adversely affecting the mortality experience of medicaid recipients. Final results will be available in mid 1983.

The final program assessment study involves the mentally retarded and developmentally disabled (MR/DD). The intermediate care facilities for the mentally retarded (ICF/MR) benefit is one of the fastest growing benefits in the medicaid program. The University of Minnesota's Psychoeducational Studies Unit is updating a national information system on long-term care services for the MR/DD population. Included in the system will be information on licensed long-term care facilities, including certified ICF/MR facilities. National surveys of residential facilities and State statistical offices will also be conducted to monitor trends in the deinstitutionalization of this population group. Data will be gathered on the size, number, geographic location, ownership, and costs of care. Resident admission, readmission, and discharge data will also be compiled. A significant part of this project will be policy studies which address issues directly related to medicaid coverage, costs, eligibility, and utilization. Results are due in early 1984, although various policy studies will be completed before that time.

LONG-TERM CARE DEMONSTRATIONS—OVERVIEW

Our current demonstration activities are focused in four major areas of investigation: *Management* of the mix of long-term care services provided; the *types of services* provided; *reimbursement* for services; and, streamlining the *survey and certification* process. Although many of our projects address more than one area, the following examples of each area are categorized according to their primary focus. For a more complete description of our demonstration activities, project summaries, and current findings follow this section.

I. Management

The coordination and management of an appropriate mix of health and social services directed at individual client needs is hypothesized to reduce institutionalization and costs without sacrificing quality of care.

HCFA funds a number of community care projects which include such common elements as client assessment, care planning, and case management. Evaluations of these projects are providing preliminary data regarding the impact of these management techniques on client characteristics, costs, and utilization of services, and client outcomes.

In September 1980, the Department announced implementation of the national long-term care demonstration program. Program responsibility for this effort is shared by ASPE, HCFA, and AoA. Ten sites are participating in the national channeling demonstration—experiments involving assessment and case management. These projects utilize a common assessment instrument and evaluation design. Some provide payment for additional services beyond those currently available under Federal programs.

See report of the Office of the Assistant Secretary for Planning and Evaluation for further information about the vocational long-term care demonstration project.

II. Types of Services

Medicare and medicaid coverage of long-term care services is restricted to services primarily medical in nature and is restricted to provision of such services in specific settings. It is hypothesized that payment for certain quasi-medical services, or changes in the location of services, can reduce the overall costs of long-term care.

During fiscal year 1980, HCFA implemented the hospice demonstration project which permits the waiver of certain statutory and regulatory requirements in order to allow coverage of hospice services provided to medicare beneficiaries and medicaid recipients. The 26 participating hospices were reimbursed under the demonstration for a number of items and services not currently covered by medicare and medicaid. Examples include: Outpatient prescription drugs, institutional respite, and home respite services (primary cargiver relief), visits by dieticians and homemakers, supportive and counseling visits to hospice patients during occasional hospital stays, continuous care (by nurses, home health aides, or homemakers) on a shift basis in the home, certain self-help devices, inpatient hospice care, and bereavement services to family members.

In 1982, Congress passed legislation incorporating many of the services and coverage criteria of the hospice demonstration. As a result of the legislation, the 26 sites will continue to receive reimbursement beyond the previously scheduled termination date of March 1983.

The Departments of Housing and Urban Development (HUD) and HHS are jointly funding a demonstration to test whether the chronically mentally ill can be deinstitutionalized and integrated into the community by providing housing support and medicaid coverage of services such as life skills, transportation, and supervision.

III. Reimbursement

Innovative reimbursement methods are being tested to determine whether they reduce costs without adversely affecting patient outcomes.

In the social HMO project, the concept of providing a continuum of medical and health services to an elderly population, within an HMO context, is being tested by brandeis University. The activities that will take place in this project are the development of a demonstration and evaluation protocol for the social HMO concept, the selection of and developmental assistance to three sites, and the implementation of the social HMO demonstration.

IV. Survey and Certification

Scarce surveyor time is being reallocated to test the impact of changes in the current survey and certification methods for determining quality of care in long-term care institutional settings.

ORD has been conducting projects in Wisconsin, Massachusetts, and New York which streamline the nursing home survey and certification process.

In Wisconsin and New York, the goal is to move from a single "paper review" of patient care and a facility's ability to meet Federal/State standards to a screening approach which focuses surveyor time on the actual care provided to patients and the facility's ability to provide that care.

While the Massachusetts project does not change the current medical review (MR)/independent professional review (IPR) requirements, it does concentrate surveyor time on identifying nursing homes which have had difficulty with Federal/State conditions of participation.

It is anticipated that findings from these three projects will be instrumental in the development of more effective nursing home survey and certification methods in which surveyor time is better utilized.

ORD'S FUTURE LONG-TERM CARE DEMONSTRATIONS

ORD's future long-term care demonstration directions are focused on four broad areas of investigation: *Prospective payment systems, development of informal supports,* the *expanded role of nurses in long-term care,* and *urban swing-bed demonstrations.*

I. Prospective Payment Systems

As a result of ORD's demonstration experience, coupled with the interest of the health care community, HCFA plans to conduct a comprehensive demonstration about prospective rate payment systems for home health agencies. ORD is in the process of developing the guidelines and specifications for this project and anticipates awarding a contract to design the demonstration by September 1983. In addition, future plans in this area include the development of a demonstration design to test the feasibility of competitive bidding for home health agencies.

II. Development of Informal Supports

Largely as a result of earlier project experiences, ORD recognizes the importance of encouraging the development of an informal and voluntary network of support which will complement the existing formal service network in allowing individuals to remain at home as an alternative to institutionalization. HCFA intends to implement studies which will test the impact of financial incentives and the necessary supports which are beneficial in fostering care at home.

III. Expanded Role of Nurses in Long-Term Care

ORD will also be investigating the expanded role of nurses in the long-term care area. Efforts in this area are in the early planning stages. However, demonstrations to test the feasibility and cost-effectiveness of reimbursing geriatric nurse practitioners on a fee-for-service basis either in a skilled nursing facility or the community are being considered.

IV. Urban Swing-Bed Demonstrations

Finally, an invitation to participate in an urban swing-bed demonstration which builds on ORD's rural swing-bed experience will be issued by the end of fiscal year 1983. HCFA expects to jointly fund this demonstration with the Robert Wood Johnson Foundation. The demonstration will be implemented in hospitals in several metropolitan areas across the country.

PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA)

The National Institute on Alcohol Abuse and Alcoholism carried out the following activities relating to the elderly during fiscal year 1982:

—Awarded a $206,004 grant to the University of Florida for a National Alcohol Research Center on the effects of alcohol on the elderly (as required by Public Law 97-35).

—Continued to cooperate with the Health Care Financing Administration in demonstrating the feasibility and effectiveness of providing alcoholism treatment services under medicare in freestanding residential and outpatient settings.

—Collaborated with intramural research staff of the National Institute on Aging on projects designed to improve the identification of drinking patterns that increase the risk of cognitive loss.

—Served on the National Institute on Aging's Ad Hoc Interagency Committee on Research on Aging, which is currently reviewing federally supported research on aging to identify areas needing exploration.

—Published (1) a chapter on alcohol use and alcohol problems among the elderly (written by Edith L. Gomberg, Ph. D.) in "Alcohol and Health Monograph 4: Special Population Series," and (2) a brief paper on alcohol and the elderly for use in responding to public inquiries on this topic.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

The National Institute on Drug Abuse (NIDA), in carrying out its mission in drug abuse research, information dissemination, and assistance to a national network of drug abuse prevention and treatment programs, performed the following activities relating to the elderly during fiscal year 1982:

—NIDA is represented on the National Institute on Aging Ad Hoc Interagency Committee on Research on Aging (IACRA). The committee is currently reviewing federally supported research on aging to identify areas that need to be explored. One such area is the issue of special consideration for the aging as a factor when new drugs are being tested for abuse potential. IACRA will consider this issue.

—NIDA issued a report entitled, "Drug Taking Among the Elderly" as part of its "Treatment Research Report and Monograph Series" which reports on a study to explore the dangers of drug misuse among older persons. In large part, the study makes the case for a responsible and cautious approach to drug taking among the elderly.

—NIDA awarded a grant to the University of California at Berkeley to examine the ways elderly people cope with stress. The study will attempt to identify cases of drug abuse and relate them to stress and coping factors. This study should greatly increase our knowledge of the nature and psychological effects of drug abuse among the elderly.

—NIDA has prepared a publication entitled "Drugs and the Elderly Adult" as part of its "Research Issues Series." The report contains an extensive bibliography, abstracts of important articles, and summaries of content areas relating to the issue of drug abuse and the elderly.

NATIONAL INSTITUTE ON MENTAL HEALTH (NIMH)

The Center for Studies of the Mental Health of the Aging is the focal point for aging programs in the Institute. The major role of the Center is to stimulate, coordinate, and support research, training, and technical assistance efforts relating to aging and mental health. The Center staff consists of seven professional and four support staff members and one visiting scientist.

This report provides information on development in mental health services to the elderly and then presents program developments in the areas of research, research training, and clinical/services training.

MENTAL HEALTH SERVICES FOR THE ELDERLY

The President's Economic Recovery Program of 1981 replaced the Mental Health System's Act, which had a provision to fund mental health services to the elderly, with the alcohol, drug abuse, and mental health services (ADAMHS) block grant to States. Section 1914(a) (B) (iii) (Public Law 97-35) identifies support of mental health services for the mentally ill elderly as a legitimate use of ADAMHS block grant funds. The relevant passage reads as follows: "Identification and assessment of mentally ill elderly individuals and provision of appropriate services to such individuals"

In the State applications for block grant funding, submitted for fiscal years 1982 and 1983 States that have mentioned the needs of the elderly have sought technical assistance and consultation from the Division of Mental Health Service Programs and from the Division of Special Mental Health Program. Concurrently, in an effort to disseminate information to the field the Division of Mental Health Service Program distributes a 1 page information sheet which high-lights a particularly useful, innovative, or relevant piece of information. In the past it has touched on mental health issues of the elderly populations.

The goal of the alcohol, drug abuse, and mental health block grant is to have the State decide what mental health services are to be provided, to whom, and in what areas. The State is able to set priorities for use of Federal funds in areas determined appropriate, and for population groups determined to be most needy.

Current Program Activities

Research support

The research program of the Center for Studies of the Mental Health of the Aging is divided into five general areas of support: Epidemiology, clinical research, treatment assessment studies, services research, and prevention and behavioral studies. The Center supports those studies which have a primary focus on the mental health and illness implications of the aging process and of old age. A wide-ranging, multidisciplinary set of theoretical, applied, and policy studies is funded. Almost all of the Institute's research support programs are involved in this NIMH/ADAMHA-wide, coordinated effort. In this way, NIMH has not only mounted a targeted effort in aging through its Aging Center, but has also brough the strengths of all its generic programs to bear on mental health and aging programs. In additions the Center has been active in stimulating collaborative efforts between different Federal programs and agencies. Diverse strengths and limited funds are brought together through the program coordination plan developed by the NIMH Center for Studies of the Mental Health of the Aging. The Center's research program emphasizes the following subjects:

- —Causes, Treatment, and Prevention of *Alzheimer's Disease, Senile Dementia, and Related Disorders* (with attention to differential diagnosis and memory-enhancing agents).
- —Causes, Treatment, and Prevention of *Depression* in older persons (including investigations of the relationship of depression to suicide, alcoholism, medical disease, and other behavioral disorders).
- —*Psychopharmacology and Polypharmacy.*
- —*Behavioral Medicine and the Interface of Physical Illness and Mental Disorder in Later Life.*
- —*Chronically Mentally Ill Elderly.*
- —*Treatment Intervention, Clinical Trials, and Service Delivery Models* for the Elderly.
- —*Effects of Families, Support Systems, and Self-Help Groups on the Care of Older Persons with Significant Mental Disorders.*
- —*Prevention of Pathology Among Elderly at Risk for Mental Illness.*
- —*Geriatric Mental Health Academic Awards* for the support of teacher/investigators in psychiatry and psychiatric nursing.

These areas of support have emerged and been refined through a considerable amount of interaction with the field and with staff of other agencies in government. These activities have included a general conference on research directions for the newly established coordinating responsibilities of the Center (1975) followed by two more targeted conferences on senile dementia, assessment, housing for deinstitutionalized elderly, depression, the chronically mentally ill elderly, and others. In addition, staff of the Center were key participants in the Secretary's Committee on Mental Health and Illness of the Elderly (1978), the President's Commission on Mental Health (1978), and the White House Conference on Aging (1981). The reports of these efforts have also been useful in setting the research agenda for the Center.

These activities have been developed in the face of substantial need in the field of mental health and aging. Five percent of the Nation's aged live in institutions. Of these, about 12 percent are in mental hospitals with the remainder in nursing and other types of homes for the aged and chroncially ill. The elderly comprise 6 percent of additions to State and county mental hospitals and 29 percent of the resident patients. Approximately 80 percent of those aged 65 and older who live in nursing and personal care homes have some degree of mental impairment. Only 3.8 percent of outpatient psychiatic service admissions are aged 65 and over. An estimated 10 to 25 percent of the aged in the community have some degree of mental impairment. The death rate for suicide among the elderly is highest at age 55 and over (18.5 per 100,000 as compared with 12.6 per 100,000 for all ages). Approximately 45 percent of all male admission aged 55 and over to inpatient services of State and county mental hospitals had a primary diagnosis of alcohol disorders.

Research highlights

(1) Differential diagnosis of senile dementia.—A recurrent problem in clinical research and treatment of elderly persons is the differentiation of normal, age-based changes from pathological states and, among these, of changes due to senile dementia from those due to depression. Memory loss and general cognitive change, mood changes, alterations in sleep patterns, and energy deficits have all been identified in this process. Projects dealing with Assessment (Ferris 32577), clinical course (Berg 31054), model diagnositc procedures (Larson 32668), and sleep problems (Prinz 33688; Weitzman 28460) are all leading to significant advance in the field. The Weitzman project (28460) illustrates, in addition, the benefit of collaborative funding approaches in that the project is supported by NIA and by NIMH and within NIMH support is split between the Clinical Research Branch and the Aging Center.

(2) *Memory enhancing agents.*—Problems with memory are often the earliest signs of development of senile dementia. One important hypothesis in the etiology of senile dementia involves a cholinergic deficiency. Different approaches to treatment have emerged from the cholinergic hypothesis, but results to this point have not been promising (Ferris 29590; Corkin 32724). A recent development of combinations or "cocktails" of choline and piracetam (Ferris 29590) has shown some interesting possible synergistic effects and these are being pursued in present studies. Unintended cognitive effects of medical treatment are also being examined in the case of a large field trial of systolic hypertension control in the elderly. In this study the Aging Center is collaborating with NHLBI through a reimbursable agreement.

(3) Prevention of inappropriate institutionalization in the elderly.—National expenditures for nursing home care are over $20 billion; close to 60 percent of this amount is public funds, principally medicaid. In 1978, 39 percent of all medicaid benefits were for nursing home expenditures (Working Papers on Long Term Care, OASPE/DHHS, October 1981). Over 80 percent of the nursing home population has significant mental health problems, with senile dementia being the most frequently observed condition. Yet, epidemiological evidence points to the fact that there are at least as many dementia patients in the community as there are in nursing homes.

The issue, then, is to account for this—namely, what keeps older disabled persons out of institutions. Research supported by the Center for Studies of the Mental Health of the Aging clearly points to the supportive influence of the family (Poulshock 35360; Brody 35252). Studies also show, however, that families pay a high emotional price for taking on the tremendous burden of care (Becker 33779; Niederehe 35400) It is likely, however, that families can be supported through psychosocial interventions to better deal with the stresses of caregiving (Steuer 37053; Zarit 34507). With the development of effective interventions, it is anticipated that institutionalization can be significantly altered and restricted to only those persons whose disabilities are so overwhelming that institutional placement is the only reasonable choice for a family.

(4) The geriatric mental health academic award.—The purpose of this award is to assist in the development of a research-oriented resource person in geriatric mental health in academic settings. Upon completion of the award, the nominee is expected to function as: (1) A researcher in geriatric mental health; (2) a developer of other researchers with interests in geriatric mental health; and (3) an introducer of research findings in geriatric mental health to other clinical teachers and researchers in the academic setting. This academic award will support an experienced faculty member, who is a psychiatrist or psychiatric nurse, in the development of necessary expertise in the research aspects of aging and metal health. This award, made to an institution provides a superior candidate with opportunity for up to 3 years of special study and supervised experience to prepare the individual to assume a faculty leadership role in geriatric mental health.

The academic award is designed to provide support for individuals with high potential for academic research careers in geriatric mental health. The academic award differs from the research scientist development award in that the nominee is expected to assume leadership in teaching and to be a research resource as well as researcher, while the research scientist is expected to be a full-time research investigator. The academic award differs from the individual national research service award in that the focus goes beyond pure preparation in research to the development of an institutional resource.

This program was initiated in 1982 and the first awards will be made in 1983.

Collaborative activities

(1) Cofunding with other NIMH, PHS, HHS or programs outside HHS.—Not all research in mental health and aging can or should be supported or administered by the Aging Center. In fields with strong and well-established technologies, such as

psychopharmacology and epidemiology, specialized expertise already exists in other programs. Similarly, certain research issues are best conceptualized as life-course of adulthood issues in which the elderly fit only as part of the study. In these types of circumstances, the Aging Center has established mechanisms for joint funding while still maintaining fiscal control of the funds. Projects have been cofunded with other programs of the NIMH, with the National Institute on Aging, with the National Institute of Neurological and Communicative Disorders and Stroke, with the National Heart, Lung, and Blood Institute, with the National Center for Health Statistics, with the Administration on Aging, and with the National Institute of Handicapped Research of the Department of Education. In this way the total aging effort of the Institute is expanded and multiplied.

(2) Interagency collaboration.—There are many Federal agencies with programmatic responsibility for dealing with the aged. Consequently, many approaches, both formal and informal, have been established for coordination and joint program development. Examples of these are as follows: Intergovernmental Science, Engineering and Technology Advisory Panel; Long-Term Care Task Force; Information and Referral Work Group; Senile Dementia Initiative; Retirement Age of Airline Pilots; and Rural Services Task Force.

Among the many specific examples of collaborative projects, two are especially notable. First, in the area of senile dementia, the NIMH Aging Center, in collaboration with two NIH institutes (National Institute on Aging and National Institute of Neurological and Communicative Disorders and Stroke), sponsored two international conferences on Alzheimer's disease/senile dementia. These conferences, the first ever held, helped establish the state of the art in research, treatment, services, and policy in this disease. Second, in the area of service delivery, a regional training conference cosponsored by the Administration on Aging and the NIMH was held as the first formal step toward local-level collaboration of aging and mental health services. This approach was repeated two more times in fiscal year 1981 so as to gain coverage of the entire Nation.

(3) Relationships with the National Institute on Aging (NIA).—The mandate given to the NIMH by the Congress is to conduct a program of research, training, and services for the prevention and treatment of mental illness and for the maintenance and improvement of the mental health of the Nation. Since persons 65 years of age and older now constitute approximately 11 percent of the population and display the highest incidence of new cases of psychopathology, a significant portion of the NIMH effort should be directed toward the mental health problems and needs of this age group. The basic focus of NIMH efforts must be on mental health. When applied to this age group, the essential considerations are the manner in which aging affects mental health and influence of mental health upon aging.

In this context, NIA's interest starts with the aging process itself, whereas NIHM's approach begins from the perspective of the mental health and illness of older people. From another vantage point, while NIA looks at biomedical, social, and behavioral aspects of aging with regard to development, NIMH studies adaptive and aberrant psychosocial functioning of the elderly with attention to etiology, prevention, treatment, and service delivery as they relate to mental disorders in later life. The two institutes also differ in a fundamental structural sense. NIA's focus is restricted to research and research training, while NIMH's Aging Center program encompasses services and clinical training in addition to research and research training efforts.

Since 1974, staff of the NIMH Center for Studies of the Mental Health of the Aging have served on the Interagency Committee on Research in Aging. This committee, chaired by the Director, NIA, and in conjunction with the National Advisory Council on Aging, helped define the research goals of the NIA and now meets regularly for purposes of coordination and consultation.

In addition, staff of the Center, together with NIA staff, also serve on the Interdepartment Committee on Aging conducted under the auspices of the Administration on Aging.

Finally, a considerable array of formal and informal relationships exists between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging. Research applications of interest to both organizations are dually assigned. On occasion, projects with dual assignments, approved by the primary institute but for which sufficient funds are not available, have been transferred to the secondary institute for funding consideration.

(4) Private sector collaboration.—Collaborative activities with the private sector during the past 18 months include the following:

(a) Consultation to management of nearly 20 major pharmaceutical companies aimed at strengthening and directing investment in geriatric psychopharmacology.

(b) Formal symposia in geriatric psychopharmacology conducted at headquarters of Dow Chemical, Merill Pharmaceuticals, Searle, Sandoz-U.S., Upjohn, Lederle, Ciba, Sandoz-Basel, Hoechst Chemical, Dupont, U.S.V. Laboratories, Mead-Johnson, Ives Laboratories.

(c) Collaborative project on assessment in geriatric psychopharmacology to result in 1982 publication involves FDA and 15 pharmaceutical companies.

(d) Physician education: (1) Distribution of "Physicians Handbook on Psychotherapeutic Drug Use in the Elderly" to 100,000 primary care physicians in collaboration with Pfizer, Wyeth Labs, and Dow Chemical. (2) Distribution of "Physicians Handbook on the Diagnosis and Management of Depression" to 100,000 primary care physicians in collaboration with Ciba-Geigy. (3) Upcoming publication on sleep problems in elderly with Upjohn. (4) Upcoming publication on senile dementia with McNeil.

(e) Distribution of "Strategies for the Development of an Effective Treatment for Senile Dementia" to 10,000 researchers in collaboration with AT&T, Sandoz, McNeil, and U.S.V.

(f) Major project with Lederle on development of equivalent human and animal models for evaluation drug effects in senile dementia.

(g) Consultation with aluminum industry on possible role of aluminum in senile dementia.

(h) Consultation with distillery industry on issues related to alcohol use in the elderly.

Research dissemination activities

The Center for Studies of the Mental Health of the Mental Health of the Aging uses a number of methods to let scientists, practitioners, and other interested persons know not only about NIMH research projects on mental health and illness of aging persons, but also in efforts to stimulate other research which may help in resolving major mental health problems of the aging. One effective method for dissemination has been through publication of summaries of NIMH research projects, some of which are in process and others on which results can be reported. These summaries are written so as to be intelligible not only to scientists but to practitioners and other interested persons.

Conferences have also been developed on areas of mental health and illness about which little is known and on which it seems important to stimulate research. For example, a conference held on June 7-8, 1982, was sponsored by the Center and brought together an international group of scientists to discuss what is known about "Schizophrenia, Paranoia, and Schizophreniform Disorders in Later Life." It was thought that through examination of the present state-of-the-art on this topic, new research directions might be developed.

Another way to disseminate the results of research projects which are particularly relevant has been through developing the final reports of important projects into monographs which can be useful to the persons who work with the mental health problems of the aging. An example of this was the publication entitled "Social and Medical Services in Housing for the Aged." This monograph may be useful to housing administrators, planners, practitioners, etc., in understanding the kinds of support needed by the aged in their housing in order to sustain their mental health.

Still another method has been the use of contracts to develop basic books which are not available on aging and mental health. An example of this is "Handbook of Mental Health and Aging." This is a definitive reference book of original contributions which reviews the theory, research, and current practice of mental health and aging.

Other ways of disseminating research results include speeches at national and international conferences and consultation with individuals, all of which our program staff carries out.

Research training support

National research service awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, provide support for the training of research scientists in the area of mental health and aging. Research training is just beginning as a Center program. As the research program of the Center gains strength and visibility, however, additional research training programs may be initiated.

The current, agencywide announcement on research training programs (issued in August 1981) reflected a strong interest in aging.

Clinical/services training support

The program in personnel development and training has focused on three major efforts: Education in the mental health specialty disciplines (psychiatry, psychology, social work, and nursing) and at the paraprofessional level; inservice training and continuing education for those within the established mental health service delivery system as well as for those within mental health support systems (e.g., primary health care, senior centers, long-term care facilities, etc.); and faculty development awards in psychiatry and psychiatric nursing.

As part of the President's program for economic recovery all mental health clinical training programs were to be phased out by the end of fiscal year 1982. The continuing resolution under which the Department operated in fiscal year 1982, however, contained provision for the support of new and continuing clinical training grants. In fiscal year 1982 NIMH supported a total of 39 training programs in which the primary focus was on the mental health of the aging.

Research Profile, Center for Studies of the Mental Health of the Aging

Grant #	P.I.	Title	FY'82 Total (DC & IC)
A. - Epidemiology		T O T A L -	$ 5,270,711
37144	O'Hara	Prevalence of Depression in the Rural Elderly	13,792
35386	Blazer	Epidemiologic Catchment Area - Duke University	161,417
33870	Kramer	Epidemiological Catchment Area	209,000
32885	Vaillant	Effect of Mental Health Upon Aging	51,513
			435,722
B. - Clinical			
31054	Berg	Mental Health in the Aged: Biomedical Factors	95,325
37026	Katz	Mental Health and Aging: Delineation of Depression	50,749
33688	Prinz	Sleep/Waking Patterns in Dementia	116,580
33841	Larson	Dementia and Mental Health in the Aged	57,856
33704	Palmore	Mental Illness and Social Support Among the Very Old	149,610
36205	Jarvik	Alzheimer Type Dementia: A Biobehavioral Family Study	249,894
36969	George	Mental Health, Brain Impairment and Aging	153,229
35400	Niederehe	Family Dynamics and the Care of Aged with Dementia	78,477
35174	McGlashan	Prediction and Outcome of Psychopathology with Aging	25,656
00125	Coyle	Neuropsychiatric Disorders: Selective Neural Loss	19,521
28460	Weitzman	Psychoneuroendocrine Rhythms and Sleep Disorders	135,000
C. - Treatment			1,131,897
32157	Thompson	Psychotherapy for Depression in the Elderly	195,696
35196	Georgatis	MAOI Vs. TCAs in the Treatment of Geriatric Depression	154.598
36135	Silberschatz	Process and Outcome of Psychotherapy with Older Adults	76,110
36596	Reifler	Mental Health in the Aged: Combined Depression and Dementia	78,318
29590	Ferris	Psychopharmacology of Neurotransmitter Systems in Aging	80,883
32724	Corkin	Lecithin Precursor Treatment in Alzheimer's Disease	179,940
36609	Tinklenberg	Neuropeptides, Mood and Memory in the Elderly	22,749
34277	Kilby	Age Effects and Animal Models of Abnormal Behavior	17,761
34720	Tecce	Neuropsychopharmacological Studies of Sleep & Aging	43,381
34223	Shader	Clinical Applications of Pharmacokinetics in Psychiatry	40,000
			1,085,132

1982

D. - Services

32731	Barbaccia	Adjustment of Older Persons after Acute Hospitalization	78,663
34426	Koh	Adaptive Capabilities of Newly Immigrated Asian Elderly	80,072
			158,735

E. - Behavioral Science/Prevention

37053	Steuer	Support Groups for Families of Dementia Patients	44,916
36834	Farberow	The Bereavement Process in Spouses of Elderly Suicides	60,549
36264	Huyck	Aging Patents, Young Adult Children, & Mental Health	122,441
34507	Zarit	Family Interventions for Senile Dementia	89,710
35724	Cohen	Old Men on the Bowery in the 1980's: Adaptive Strategies	90,462
36615	Haan	Personality and Mental Health Across the Life Span	59,439
35630	Johnson	Grandparents Role in the Divorce Process	96,679
31095	Scheidt	Mental Health & Environmental Adaptation of Rural Elderly	99,864
35312	Lawton	Old & Alone: Gender, Marital Status & Mental Health	159,786
35360	Poulshock	Care for Elders and Mental Health of Family Members	110,719
33645	Okimoto	Mental Health of Aging Japanese Americans	83,750
33779	Becker	Stress Vulnerability in Alzheimer Patients' Families	97,473
35252	Brody	Women, Work & Care of the Aged - Mental Health Effects	94,170
32260	Ostfeld	Effect of Spousal Illness & Death in Older Families	272,403
36290	Bengtson	Mental Health & Intergenerational Solidarity	78,800
37714	Kahana	Mental Health Implications of Extreme Stress	119,094
37707	Lawton	The Last Year of Life: Mental Health Aspects	124,729
33713	Fiske	Mental Health - A Longitudinal Study of Adaptation	65,380
32305	Chiraboga	Mental Illness & Divorce: A Life Span Study	28,861
			1,899,225

D. & E.	Emerging Issues (Contracts)	170,000

Reimbursables

NIHR	200,000
Heart, Lung, Blood	150,000
HANES-I FOLLOWUP (with NCHS)	40,000
	390,000

FOOD AND DRUG ADMINISTRATION

Although the activities conducted by the Food and Drug Administration (FDA) have a great impact on all consumers, the elderly, a group which uses more drugs and often has special nutritional needs as well as economic limitations, are directly affected by Agency programs in many ways. As an increasing segment of our population, the elderly have received more attention, and much progress has been made toward meeting this group's special needs. Some of the major initiatives underway at the FDA are described below.

PATIENT EDUCATION

Because the elderly are prescribed more drugs than any other segment of the population and changes in body function due to aging occur, the importance of proper drug use, understanding of drug interactions, and patient recognition of possible adverse reactions becomes even more crucial to good medical care. As a group, older persons should be encouraged to discuss more fully with their physicians and other health professionals their questions about medications and any problems that may occur.

To further this end, the Committee on Patient Education was appointed in January 1982 by Commissioner Hayes at the direction of Health and Human Services Secretary Schweiker. Its goals are twofold: To coordinate the Governments's efforts to advise consumers about prescription drugs; and to serve as a catalyst for private-sector initiatives in this area. In addition, FDA is a founding member, along with many medical organizations and pharmaceutical companies, in the National Council on Patient Information and Education, chaired by Paul G. Rogers, a nongovernmental group whose goal is to stimulate patient education program development. With so many efforts underway at these levels, progress has already been made in programs that focus on encouraging health professionals to provide more information to patients and encouraging patients to seek more information about drug use. Making people aware of their own responsibility in their health care has been one of the very positive achievements of these programs.

Patient information about drugs is now being distributed by the American Association of Retired Persons (AARP) through their pharmacy service, as well as by physicians through the American Medical Association (AMA) patient medication information (PMI) program. FDA has worked closely with both groups to encourage development of these efforts.

PROMOTING "WELLNESS"

Major efforts this year have been undertaken through public service announcement (PSA) campaigns. These spots on radio, TV, and printed in newspapers have increased consumer awareness of major health issues. These include several PSA's focusing on items of particular importance to older persons—the influence of sodium on hypertension and, in response to package-tampering incidents, programs that focus consumer attention on package integrity.

NEW DRUG APPROVAL

To expedite the approval of new drugs is to speed the availability of scientific improvements, and in some cases, lifesaving advancements in medicine. Thus, much attention has been focused on more efficient management to decrease time frames now associated with the new drug approval process.

At the direction of HHS Secretary Schweiker, a study has been conducted of the paperwork flow and decisionmaking process associated with new drug review. As a result, several recommendations in the report that will further reduce approval times have already been implemented or will be implemented shortly.

Internal management changes and priority setting for "fast-track" drugs have already decreased review time for important new drugs. During the fiscal year that just ended (fiscal year 1982), and for the second consecutive year, more than 20 important new molecular entities were approved for marketing. FDA's efforts in evaluating the drug approval process culminated in our publishing a proposal to revise the new drug approval regulations. Several new drugs representing major progress in health care for the elderly have recently been approved. Among them are nifedipine, a calcium channel blocker used to treat angina pectoris and Timolol, a beta-blocker specifically indicated for use in preventing death and further heart attacks among people who have survived an initial heart attack.

MAXIMUM ALLOWABLE COST (MAC) PROGRAM

The elderly in our population, as users of more medications than other groups, benefit more directly from FDA's review of drugs to establish therapeutic equivalence. Name brand drugs, often marketed at high cost, can in many cases be substituted with a lower cost generic equivalent. This is the basic philosophy underlying HHS' MAC program, through which a maximum cost is established for drugs paid for under tax-supported reimbursement programs such as medicare and medicaid. Continuing review of marketed drugs enabled the FDA to expand its listing of therapeutic equivalents, thereby providing more assurance to the elderly that the drugs they need to take can be obtained at the lowest possible cost with no sacrifice in effectiveness.

AD HOC INTERAGENCY COMMITTEE ON RESEARCH AND AGING

FDA has continued to participate in meetings of the Ad Hoc Interagency Committee to further strengthen our liaison with the National Institute of Aging (NIA). The meetings have focused on the development of new drugs for diseases found more frequently in the aging segment of our population. FDA recently took the initiative in setting up a working group with ADAMHA, consumer groups, and NIA for the purpose of outlining special concerns in the development of drugs for use by the elderly. The working group will encourage recognition of this field and seek to define more specifically the special needs of an aged population group. They will also try to define parameters and guidelines for testing drugs, taking into account changes in body functions which affect metabolism.

FDA is also giving increasing attention to information pertinent to the elderly (warnings, precautions, dosage, and administration) for marketed drugs. In conjunction with patient education programs that are underway, this will help older Americans and their physicians to utilize drugs to their best advantage.

PARTICIPATION BY THE ELDERLY IN DRUG EXPERIMENTATION

FDA continued its efforts in Institutional Review Board (IRB) education. IRB's govern the review and conduct of all human research involving products regulated by FDA, regardless of whether the human subjects are institutionalized or are outpatients. Their review of research protocols and informed consent processes must include the determination that adequate protection is afforded to all subjects, particularly in the case of vulnerable groups, in which category the elderly may often fall.

FDA, jointly with the National Institutes of Health (NIH), held three workshops (aimed primarily at IRB members, institutions, and clinical investigators) on the IRB and informed consent regulations. These were the last in a series of nine workshops jointly sponsored by FDA and NIH. On September 2, 1982, FDA sent over 2,000 letters to members of the IRB community informing them of the availability of information on IRB and informed consent regulations. Included with this letter were seven information sheets on subjects of interest on IRB's and clinical investigators. Response to the letter has been substantial, and nine more information sheets are under development.

SELECTED DEVICES OF BENEFIT TO THE ELDERLY

INTRAOCULAR LENSES

The clincal data for several models of intraocular lenses (IOL's) of several manufacturers have been reviewed by export consultants and by FDA staff, and it has been concluded that these data establish that the particular lenses are safe and effective. The data demonstrate that a high proportion (85 to 95 percent) of the patients will be able to achieve 20/40 or better vision with the implanted lenses and that few (3 to 5 percent) will experience poor visual acuity (20/200 or worse). The data also demonstrate that the risks of experiencing a significant post-operative complication are not great. Furthermore, many of these complications result during the early post-operative period and are associated with cataract surgery. The incidence of these complications is generally not affected by IOL implantation. Approved lenses have a significant impact on the health of elderly patients having surgery to remove cataracts. The IOL's, because they are safe and effective, aid elderly patients by increasing the options available to maintain their sight and thus their ability to drive and otherwise lead normal lives. The costs of IOL implantations are competitive with other available options, particularly when the continuing costs of contact lens care accessories, such as cleaning and storage solutions, disinfection solutions, or heat disinfection units are considered.

On March 2, 1982, FDA approved the Planar Open Loop Posterior Chamber Lenses Models 101, 101B, and 101T. These models are the first posterior chamber intraocular lenses (IOL's) approved by FDA. These particular lenses were approved for use in patients 60 years of age or older who have no contraindications to IOL's. Intraocular lenses can be especially helpful to elderly persons who may have difficulty handling contact lenses but cannot see well with glasses alone.

HEARING AIDS

Hearing aids enable senior citizens with amplification impairment to do more than just cope with their disability . They provide them with the ability to carry on useful and functional lives. Our older citizens become very fearful when they cannot hear sounds they once heard. They slowly retrogress, spending more time at home withdrawing from society and from family members. Eventually, they may become nonfunctional and require care. Communication is their window to the enjoyable aspects of life; when they lose it, the process of degeneration slowly takes over. Hearing aids can restore amplification and bring the familiar sounds back into their lives. The day-to-day problems of the hard of hearing can be eliminated with hearing aids, enabling them to enjoy and participate in all there is around.

FDA requires a prospective purchaser of a hearing aid to undergo a medical evaluation no more than 6 months before the sale of a hearing aid to determine the cause of the hearing loss. However, an informed adult, 18 or older, is permitted to waive the medical evaluation before the sale of a hearing aid.

PACEMAKERS

Dysfunctions of the electrophysiology of the heart can develop with age, be caused by disease, or result from surgery. People with this condition can suffer from fainting, dizziness, lethargy, heart flutter, and a variety of similar discomforts or ills. More seriously, such life-threatening conditions as congestive heart failure or fibrillation can occur. FDA is responsible for policy on the safety, efficacy, and labeling of cardiac pacemakers.

The modern pacemaker is designed to supply stimulating electrical pulses when needed to the upper or lower chambers of the heart or, with some newer models, both. It has corrected many of the above pathological conditions for a large number of people. Approximately half a million elderly persons have pacemakers. At present, an estimated 125,000 pacemakers are implanted annually, 30 percent being replacements. An estimated 75 percent of these are for persons 65 years of age or older. Without pacemakers, many of these people would not have survived. Others are protected from life-threatening situations and, for most, the quality of life has been improved. Pacemakers can make life more enjoyable for the patients by enabling them to lead more active lives which require less care. In general, it can be said that pacemakers contribute to the physical and mental well-being of the elderly in our population.

RADIOLOGICAL DEVICE PROGRAMS

A substantial portion of the millions of medical X-rays conducted annually in the United States are performed on elderly patients. As discussed below, FDA has participated in many activities related to protection of patients from unnecessary X-ray exposure as well as the development of new techniques in the X-ray field.

IONIZING RADIATION

A study of X-ray film processor operations in selected diagnostic radiology facilities showed variations in processor performance that may be indicative of unnecessarily high patient exposures. As a result of this study, FDA, in cooperation with the Conference of Radiation Control Program Directors, Inc., developed and began pilot testing a sensitometric technique for the evaluation of processing (STEP). The procedure takes less than 5 minutes, gives an immediate indication of processing speed, and will identify overprocessing or underprocessing. Five States are now pilot testing the STEP procedure, and current plans call for several more States to participate in these pilot tests. The program will probably be available within the next year to all States that wish to participate.

TELERADIOLOGY

The preliminary results of a 6-month field trial of the teleradiology system were presented at a conference cosponsored by FDA in August 1982. Teleradiology is the electronic transmission of radiographic images from remote clinics without specialty services to medical centers where radiologists are available.

The teleradiology system was developed to provide access to radiology services to military personnel and civilians in remote areas. This system would be particularly helpful to the elderly living in isolated areas. A field trial of the system was conducted in which X-ray examinations (performed at clinics located 10 to 150 miles from the site where the images were to be interpreted) were sent by television camera and special telephone lines to be stored on magnetic discs. During regular reading times, radiologists called up the radiographs on the discs and displayed them on video monitors for interpretation. A priority mode was available for emergency cases. Throughout the field trial, data were collected on the technical performance of the system, and a panel of senior radiologists reviewed a sample of the 5,000 cases to determine the accuracy of video interpretation. FDA has established an archive consisting of the 500 cases which were reviewed during the field trial which will be made available to qualified investigators interested in furthering the development of teleradiology.

QUACKERY

FDA has developed an agencywide comprehensive umbrella consumer education program which encompasses all aspects of health quackery, but focuses on deceptive medical devices, misrepresented drugs, and food faddism.

Quackery is a widely used term that means different things to different people. FDA's Committee on Quackery defined quackery as: "The practice of making false, misleading, or deceptive nutritional health, or cosmetic claims for FDA-regulated products which are regarded as worthless for such intended uses by experts qualified by scientific training and experience to evaluate their safety and effectiveness."

Quackery may be a serious and oftentimes expensive problem for the elderly. For example, the National Arthritis Foundation estimates that the American public pays from $5 to $10 billion a year for quackery-type frauds.

It can also pose *direct* and *indirect* health hazards as well as economic losses, to those who are misled by promises of quick and easy cures and unrealistic physical transformations. The more serious forms of quackery involve products that present direct or indirect health hazards. The former are products which, even when used as directed, have the potential to cause injury or death. The latter includes products offered for diagnosis or treatment of serious ailments, such as cancer, but that are ineffective for such use. Using these products may delay obtaining recognized medical treatment.

FDA will always respond to complaints about products that cause injuries or pose other serious health hazards. In addition, one of the objectives of FDA's consumer education program is to provide guidance that helps consumers recognize quackery, evaluate claims, and make informed decisions for themselves.

FOOD LABELING

Nutrition information is of particular value to older persons, many of whom are advised by their physician to restrict consumption of salt and other food components. Thus, the sodium labeling and cholesterol labeling programs, when finalized, are expected to have a major impact on health. FDA recently published in the Federal Register a proposed rule concerning the declaration of sodium content of foods and label claims for foods on the basis of sodium content. The purpose of this is to amend the food labeling regulations to provide more sodium information to consumers so that they can make wise food choices, and have the information they need to follow low-sodium diets prescribed by their physicians.

The proposed regulations define terms denoting levels of sodium and specify the maximum levels of sodium that a serving may contain when these terms are used on the product label.

These rules require the declaration of the sodium content on food labels which contain nutrition information. Nutrition information is required if a processor adds nutrients to a product or makes nutritional claims about it. However, the voluntary inclusion of salt/sodium information on a product label does not require the manufacturer to provide full nutrition labeling. In addition, the agency is recommending the voluntary inclusion of potassium content information in nutrition labeling because people with kidney and some other diseases who must control their sodium intake must also control their potassium intake. Also, people with high blood pressure and other related health problems ofter use potassium in place of sodium.

Many major food manufacturers have voluntarily included sodium information on food labels since FDA began its sodium education program last year. It is estimated that in 1983 more than one-third of the processed foods FDA regulates will bear voluntary sodium labeling, compared to only 13 percent in 1981. In addition, several manufacturers are marketing (or considering) foods that are lower in sodium, and some are conducting sodium education compaigns.

FDA also is working on a proposal that would amend current regulations to require cholesterol and fatty acid content of foods to be included as part of nutrition labeling when claims about these substances are made. Most consumers, but especially the elderly are vulnerable to misleading claims about the value of particular foods in preventing or treating heart and artery disease. Cholesterol and fatty acid claims have the potential to be misleading in this regard. Nutrition information about cholesterol and fatty acid content on the food label would minimize the potential for deception and aid individuals on fat-modified diets.

Food Programs for the Elderly

FDA has been involved in cooperative programs with the Federal Administration on Aging (AoA) to help open lines of communication and training between personnel involved in food service programs for the elderly and State and local food officials. In addition to providing food handling training and seminars, FDA has encouraged participation in management training and certification in food protection and sanitation. We routinely make available copies of FDA codes and guidelines as well as periodic listings of training programs.

Because AoA furnishes home-delivery meals (meals-on-wheels program) and there exist unique problems in equipment and transportation, FDA is assisting with development of, in conjunction with the University of Colorado, a new training program specifically designed to meet the needs of personnel involved in a home-delivery system. This will help to insure safer food delivery systems to a population which relies on this food assistance.

Total Diet Studies

In April the agency began a revised total diet studies program. The major changes include the use of current food consumption data developed by the U.S. Department of Agriculture (USDA) and the Natinal Center for Health Statistics, analysis of individual foods (rather than the previous food groupings or "composites"), and computerized data manipulation to permit the determination of daily dietary intakes of contaminants and elected nutrients for almost any population or age group in the United States.

Since the 1960's this program—also known as the FDA Market Basket Study—has enabled the agency to measure the levels of pesticides, industrial chemicals, toxic metals, radionuclides, and essential minerals in the diets of various components of our society. The revised program will enable the agency to determine dietary intake for almost any age population group in the United States. The program will help to identify any problems that may exist specifically relating to elderly populations.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration provides leadership and direction to programs and activities designed to improve health services for all people of the United States and to develop health care maintenance systems which are adequately financed, comprehensive, interrelated and responsive to the needs of individuals and families in all levels of society. Specifically the agency: (1) Provides leadership and support efforts designed to integrate health services delivery program with public and private health financing programs, including the health maintenance organizations; (2) administers the health services block grants, categorical grants, and formula grant-supported programs; (3) provides or arranges for personal health services, including both hospital and outpatient care to designated beneficiaries; (4) administers programs to improve the utilization of health resources through health planning; (5) provides technical assistance for modernizing or replacing health care facilities; (6) provides leadership to improve the education, training distribution, supply, use and quality of the Nation's health personnel; and (7) provides advice and support to the Assistant Secretary for Health in formulation of health policies.

The areas of responsibility as outlined above are carried out by four bureaus within HRSA as follows: Bureau of Health Professions, Bureau of Health Care Delivery and Assistance, Indian Health Service, and Bureau of Health Maintenance Organizations and Resource Development. The activities of each Bureau have a significant impact on programs and services for the elderly throughout the Nation. These activities for fiscal year 1982 are reported below.

BUREAU OF HEALTH PROFESSIONS (BHPR)

The Bureau of Health Professions provides national leadership in coordinating, evaluating, and supporting the development and utilization of U.S. health personnel. It assesses the supply and requirements of the Nation's health professions and develops and administers programs to meet those requirements; collects and analyzes data and disseminates information on the characteristics and capacities of health professions production systems; and develops, tests, and demonstrates new and improved approaches to the development and utilization of health personnel within various patterns of health care delivery and financing systems. The Bureau provides financial support on institutions and individuals for health education programs, administers Federal programs for targeted health personnel development and utilization, and provides technical assistance to national, State, and local agencies, organizations, and institutions for the development, production, utilization, and evaluation of health personnel.

Fiscal year 1982 program efforts directed toward the development of human resources needed to provide health care to the aged are summarized below for the three program divisions of the Bureau that support the effort.

DIVISION OF MEDICINE

Grant program support under title VII of the Public Health Service Act included geriatric activities. Under section 781, area health education center (AHEC) program, five medical school awardees received a total of $322,579 for geriatric medical training, impacting an estimated 3,084 individuals. The largest recipient was the University of Maryland which received $272,579 to continue its development of an area health education center program which included graduate and undergraduate medical training in an urban geriatric setting.

Thirty-four grants ($324,698) were awarded under section 786(a) for graduate training in family medicine to support specific geriatric activities. Support for activities ranged from elective course in geriatrics to salaries for geriatric consultants and instructors. Awards ranged from $2,000 to $162,918 for these activities impacting an estimated 1,229 individuals.

Also under section 786(a), faculty development in family medicine, one medical school grantee indicated an intent to develop a geriatric center and two indicated they would hold discussion series for teaching faculty in family medicine on the treatment issues in geriatric health care delivery.

Additionally, in predoctoral training in family medicine (section 786(a)), 31 grantees indicated an intent to provide curriculum content in geriatrics and gerontology to undergraduate medical students. An estimated 296 students would be impacted.

A number of activities occurred under section 783 which had a direct or indirect impact on the elderly. Eighteen physician assistant programs indicated that students would be exposed to clinical medicine lectures, geriatric health fairs or gerontological preceptorships as part of their training. An additional three programs received a total of $31,423 to support geriatric courses and workshops.

Under section 780, a total of $72,429 was awarded to 16 department of family medicine grantees to strengthen the geriatric components in these administrative units. About 310 students are expected to be impacted by these awards.

The general internal medicine and general pediatrics residency program (section 784) had 32 grantees in fiscal year 1982 which project that about 357 residents will have exposure to the aged through electives and/or optional rotations. These programs received a total of $41,527 to support these educational experiences.

DIVISION OF NURSING

Grant and contract program support under the Public Health Service Act, as amended, included geriatric activities. Special project grants activities in fiscal year 1982 under section 820 of the Public Health Service Act supported five grants targeted toward curriculum revision, with a major focus on gerontological nursing, continuing and inservice education activities to upgrade and maintain competency and skills of practicing nursing personnel which include, but are not limited to gerontological or geriatric content. A total of $660,758 was allocated in fiscal year 1982 for these purposes.

Advanced nurse training funds supported 14 projects for a total of $1,152,124 under section 821 of the Public Health Service Act to prepare nurses in gerontological nursing at the graduate level. Eleven gerontology programs totaling $1,519,769 were funded by the nurse practitioner program, section 822 of the Public Health Service Act. Additional aging programs are included in family programs funded, however the exact support level cannot be separated from the total awards.

Under authority of section 472, national research service awards (NRSA) were made to seven graduate nurses for support of their doctoral study in the field of gerontological nursing, while, nursing research grants in fiscal year 1982, authorized by section 301 of the Public Health Service Act, supported 20 projects dealing with gerontology. The total funding for these 20 projects was $567,800.

A professional services contract in the amount of $4,800 was awarded to conduct a review of pertinent literature to identify what has been studied in respect to recruitment and retention of registered nurses in nursing homes and to provide a questionnaire to gather information pertinent to these topics from registered nurses employed in nursing homes.

Additionally, the contractor will develop questions relevant to these topics to be included in a National Center for Health Statistics interview with nursing home administrators. Both the questionnaire for registered nurses and the questions for the administrator will be incorporated into the National Center for Health Statistics national nursing home survey scheduled for pretest in April 1983.

The Division convened a Task Force on Nursing Care of the Aged as a basis for formulating goals and objectives related to the needs of this population groups. Finally, two additional contracts in the Division were active:

—"The Development and Implementation of a Geriatric Educational Program for Nurses," totaling $197,626.

—"Development, Implementation and Evaluation of a Nursing Center," totaling $399,998.

DIVISION OF ASSOCIATED AND DENTAL HEALTH PROFESSIONS

Based on grants received in fiscal year 1980, health professions schools continued projects designed to improve the knowledge, skills, and practices of health professionals in assessing nutrition status in health and disease and advising and instructing patients about diet and nutrition. The grant program impacts on all types of patients, including the aged, and emphasizes interdisciplinary team training which must include medical students and at least two other professions which typically are dietitians/nutritionists, nurse/nurse practitioners and physician assistants.

The provision of adequately trained professionals available to deliver primary dental care services to the geriatric patient is a major target area. Traditional delivery methods do not always provide access to dental care for many of these individuals both in terms of availability and costs. Under current authority, training support is available through general practice residency programs, which predominantly are sponsored by hospitals and provide comprehensive dental services to the elderly.

As part of an effort to promote further organized and coordinated education in geriatrics in dental schools, the Division is supporting a project to evaluate current resources in geriatric dentistry education. The results of the evaluation will aid educational planners to determine the characteristics of geriatric dental curricula and their influences on students and dental practice. This will help dental educators to evaluate the strengths and weaknesses of their own programs, and improve their programs as necessary.

The Division is also supporting a study of the characteristics of dental hygiene practice in nontraditional settings, such as nursing homes, hospitals, and day care centers for the elderly. The increased utilization of hygienists in this manner provides a promising aproach to the increasing oral health care for the elderly, as well as other special populations. To date, there are no systematic data regarding the extent and characteristics of these practices. This information will aid both the public and private sectors in determining appropriate, further implementation and desirable expansion of such dental hygienists roles. The data will also assist dental hygiene educators in developing curricula that prepare hygienists to provide services in nontraditional settings.

BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

The Health Resources and Services Administration (HRSA) continued its support for a variety of health care programs which were widely used by older Americans in fiscal year 1982. About 400,000 people 65 years of age or older were among the 4.7 million people treated in the 588 community health centers (CHC) and 128 migrant health centers (MHC) which were funded by the Bureau of Health Care Delivery and Assistance, formerly the Bureau of Community Health Services. In fiscal year

1982, a total of 2,115 National Health Service Corps (NHSC) professionals served in health manpower shortage areas providing care to nearly 2.2 million people. The HRSA's Indian Health Service (IHS) continued to focus attention on the special health needs of older American Indians and Alaska Natives through interagency linkages and health care programs. As described below, the health care programs and services offered by the HRSA were used by older Americans who were among the medically underserved and statutorily defined beneficiary population groups served by the HRSA.

A. COMMUNITY HEALTH CENTERS

In fiscal year 1982, a total of 588 CHC located in medically underserved areas provided a range of preventive, curative, and rehabilitative services to 4.3 million persons. About 8.7 percent of those served were age 65 or older. Formal and informal linkages existed between some center grantees, the U.S. Department of Agriculture (USDA), and the Administration on Aging (AoA) to augment the number of social and nutritional programs available. These include the food stamp program, the meal-on-wheels projects, and programs in which the CHC provide service to seniors in congregate housing and sponsor multiphasic screening clinics in senior citizen centers and recreational areas. Other linkages include transportation arrangements with long-term care institutions and individual service arrangements with nonprofit senior centers and home health agencies. Special efforts have been made to integrate home health services into an overall health care package as evidenced by the certification of several CHC as medicare home health providers.

B. MIGRANT HEALTH

The MHC program provides health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are frequently scarce. The elderly migrant, beset be increasing health problems, is placed in a vulnerable position—faced with inadequate health resources and manpower, and language and cultural barriers. The MHC program authority, section 329 of the PHS Act, as amended November 1978, includes language that broadens eligibility to include a significant number of elderly and disabled. With that legislative authority, the MHC program can serve "individuals who have previously been agricultural workers but can no longer (be employed as migrant farmworkers) because of age or disability, and members of their families within the area it serves." In fiscal year 1982, services were provided to 394,000 migrant and seasonal farmworkers through 128 projects. Approximately, 5.6 percent of those served were 65 or older.

C. THE NATIONAL HEALTH SERVICE CORPS

The mission of the NHSC is to provide health manpower to American communities and population groups whose health needs are not otherwise fully met. The NHSC places physicians, dentists, nurse practitioners and other health professionals in areas that have health manpower shortages. Since older people usually have special health needs and reduced mobility, the presence of health personnel in their communities is especially important. The Corps works closely with the CHC and MHC programs and provides assistance in recruiting health manpower for these programs.

In fiscal year 1982, the NHSC affirmed its commitment of health care to the elderly. The Corps focused on geriatric medicine and other gerontological issues at the NHSC regional inservice conferences for providers and emphasized geriatric health concepts. Through various programs in communities, Corps assignees reach the elderly with programs such as nutrition counseling, high blood pressure screenings, physical therapy, and stroke prevention.

INDIAN HEALTH SERVICE

The Indian health program provides health services to approximatley 828,609 American Indians and Alaska Natives, who reside within the geographic area of about 500 Federal recognized tribal entities located in 28 States including Alaska. It is estimated that 5.2 percent (65,102) of the American Indian and Alaska Native population is 65 and over. There is a preponderance of younger persons in the IHS population; the Indian and Alaska Native median age is 22 which is lower than the median age of 30 of all races in the United States. However, attention is being focused on the needs of the elderly primarily as a consequence of both the yearly Indian conference on health of the elderly conducted by the National Indian Council on Aging and titles III and VI of the Older Americans Act.

Specific services and interagency linkages have been geared to serve the special health needs of the elderly. Services offered in conjunction with the AoA include congregate meals, meals-on-wheels, minor home repair, shopping assistance, transportation, health surveillance, outreach, part-time employment, and inservice training for titles III and VI personnel. Other linkages include the IHS medical and social service surveillance for nursing home and extended medical care patients, and assistance in obtaining services under medicare, medicaid, the USDA-administered food assistance program, Veterans Administration, and other Federal and State programs.

BUREAU OF HEALTH MAINTENANCE ORGANIZATIONS AND RESOURCES DEVELOPMENT

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS

In recognition of the advantages of health maintenance organization (HMO) membership to medicare beneficiaries, section 1876 of Title XVIII of the Social Security Act was amended in the Tax Equity and Fiscal Responsibility Act of 1982. The amendments are intended to encourage and facilitate medicare enrollment in HMO's. The Office of Health Maintenance Organizations (OHMO) is working closely with the Health Care Care Financing Administration to implement the amendments and anticipates that the determination of organizations eligible to provide services to medicare beneficiaries will be integrated with the OHMO responsibility to designate federally qualified HMO's under title XIII of the Public Health Service Act.

HMO's are interested increasingly in expanding their services to the aging. For the elderly, the comprehensive services (including preventive health services) available from an HMO federally qualified under title XIII are a significant incentive to join an HMO.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE ON AGING

INTRODUCTION

As our knowledge of the aging process increases, it is becoming evident that the body compensates for some decrements of aging, and other age-related changes may be subject to interventions. The results of research supported by the National Institute on Aging (NIA) and other Institutes at the National Institutes of Health (NIH) give rise to a more realistic—and even optimistic—view of aging, the one biological process common to all.

Although the 26 million Americans aged 65 or over make up 11 percent of the population, they account for 29 percent of health care costs. The elderly use 25 percent of prescription drugs, make 15 percent of all visits to office-based physicians, account for 34 percent of all days in short-stay hospitals, and comprise 87 percent of the residents in nursing homes.

Clearly, the results of research on aging and the special problems and needs of the elderly may lead to many benefits. Perhaps chief among them is that ways may be found to extend the years of health and productivity and reduce the period of illness and dependence that all too often characterizes the later years of life.

PROGRAM HIGHLIGHTS

FIRST TEACHING NURSING HOME AWARDS MADE

In September 1982, the NIA awarded its first two teaching nursing home grants to support research on geriatric health problems in a nursing home setting. These grants will total $7.43 million over 5 years.

Between 1964 and 1977, the number of residents in U.S. nursing homes grew from 554,000 to 1.3 million. The Nation's expenditures for nursing homes are over $24 billion a year and will probably triple by 1990.

A goal of the teaching nursing home program is to increase the understanding of chronic health problems that often lead to institutionalization of older people. Many of these problems, including senile dementia, incontinence, osteoporosis and osteoarthritis, depression, and sleep disorders, have not been the subject of extensive biomedical research interest.

The chronic care facilities to be involved under the grant to the Albert Einstein College of Medicine are the Beth Abraham Hospital, Morningside House Nursing Home, and Hebrew Home for the Aged. The participating institutions are the Albert Einstein College Hospital, Bronx Municipal Hospital, Montefiore Medical Center, and College of Mount St. Vincent. The principal investigator, Robert Katzman, is professor and chairman of neurology at the Albert Einstein College of Medicine.

In one study, the group will evaluate the effectiveness of physostigmine, a drug which may improve memory in patients with senile dementia. Another research project will examine correlations between cognitive changes in Alzheimer's disease—the most common form of "senility" among the elderly—and genetic factors. Other studies will look at causes of osteoarthritis and how problems of balance and gait (walking) are related to falls in the elderly.

The consortium of institutions involved in the grant awarded to the Philadelphia Geriatric Center include the Medical College of Pennsylvania and the University of Pennsylvania. The principal investigator, Donald Kaye, is professor and chairman of the department of medicine at the Medical College of Pennsylvania.

The research program includes a study to determine factors which affect an older person's risk of acquiring a urinary tract infection; testing of an intensive cognitive therapy for stroke rehabilitation; application of the PET (position emission tomography) scan in the study of dementias; and investigations on the prevalence and causes of sleep apnea (frequent interruptions of breathing during sleep that may be life-threatening in some cases).

CLINICAL CENTER RESEARCH UNIT OPENS

The NIA Laboratory of Neuroscience (LNS) clinical program, established in 1980, is involved in an intensive investigation of brain metabolism in relation to normal human aging and dementia. In September 1982, the LNS admitted its first impatients, thus initiating a series of activities focusing on the dementias and related neuropathological diseases of the elderly. The LNS researchers are looking closely at Alzheimer's disease and at multi-infarct dementia, which is caused by a series of minor strokes.

These studies of dementia are part of a clinical program which has been examining, and which will continue to examine, the normal aging process from biochemical, cardiovascular, and general physiological perspectives, including careful evaluation of brain function. The primary clinical goals of the new program are: (1) To develop a clearer picture of brain physiology in normal aging and age-related diseases; (2) to evaluate changes with age in the metabolism and effects of drugs that lower blood pressure and drugs that act on the central nervous system; (3) to develop a better understanding of the causes, courses, and treatments of different forms of dementia; and (4) to encourage other NIH components to focus their clinical studies on the growing aging population

The LNS staff hope to use the results of their work to design pharmacological approaches to treat reversible cognitive defects of aging and dementia and to understand better the neurochemical changes that occur in Alzheimer's disease.

RESEARCH PLAN UPDATED

Several years ago, the NIA began the process of updating the research plan on aging that was developed in 1976, shortly after the Institute's creation. The NIA assembled a panel of experts who examined the current status of research on aging and set goals, strategies, and priorities for research. This effort was recently completed and has been published as "Toward an Independent Old Age: A National Research Plan on Aging." The report, which will be instrumental in NIA program planning, includes a response from the national Advisory Council on Aging that makes recommendations about the NIA's priorities and the resources needed to pursue various goals.

FIRST NIA ACADEMIC AWARDS MADE

The first three awards have been made under a program established last year to recruit and prepare physicians for research and teaching careers in geriatrics. The NIA academic award provides an individual who has superior academic potential with up to 5 years of support for special study and supervised experience so that he or she can develop expertise in research, clinical responsibilities, and teaching in geriatrics. The award is made to an institution for a candidate who holds an M.D., D.O., or equivalent degree and who has completed at least 3 years of postdoctoral training and/or experience.

Two of the three recipients will conduct clinical research on urinary incontinence in the elderly, one at the University of California at Los Angeles and the other at Harvard University. The third awardee will engage in clinical care, teaching, and research at Harvard on the management of trauma and bone fractures in older people.

The academic award joins three other NIA-sponsored programs—the geriatric medicine academic award, the geriatric dentistry academic award, and the clinical investigator award—which are designed to encourage clinicians to pursue aging research.

SMALL GRANT AWARD ANNOUNCED

In November 1981, the NIA announced a small grant mechanism to provide 1 year of support for conducting pilot studies, testing new techiques, and carrying out feasibility studies in innovative or high-risk research. Small grants are limited to four priority areas: nutrition and health of the elderly, pharmacology and aging, senile dementia of the Alzheimer's type, and health and effective functioning in the middle and later years. The work conducted under these grants is expected to form the basis for more extensive investigations supported through the traditional research grant mechanism.

AGING, NONHUMAN PRIMATE COLONY ESTABLISHED

In cooperation with the NIH Division of Research Resources, the NIA recently established the first resource colony of aging, nonhuman primates for biological and behavioral research. This will enable scientists to study aging in animals with the greatest similarities to humans. The resource will be available to investigators for studies of tissues, organs, and physiologic fluids, as well as whole animals.

NEW PROGRAM ANNOUNCEMENTS ISSUED

During the past year, the NIA issued program announcements to encourage research on urinary incontinence and infectious diseases in the elderly, as well as on the maintenance of health and effective functioning in the later years. The Institute also published a revision of an earlier announcement designed to stimulate studies on the pharmacology of aging.

HEALTH PROMOTION ACTIVITIES EMPHASIZED

In June 1982, the NIA appointed an Assistant Director for Health Promotion to develop and coordinate activities in health promotion and disease prevention. Functions of the position include overseeing technology transfer activities; chairing the NIA Ad Hoc Interagency Committee on Research on Aging; serving as the official liaison between the Office of the Director, NIA, and the Administration on Aging; and representing the NIA on the NIH Office of Medical Applications of Research Advisory Committee and the NIH Committee on Health Promotion and Disease Prevention.

NIA DIRECTOR DEPARTS

In September 1982, Robert N. Butler resigned as NIA Director to accept positions at the Mount Sinai Medical Center in New York. As chairman of the Gerald and May Ellen Ritter Department of Geriatrics and Adult Development of the Mount Sinai School of Medicine, Butler is heading the country's first department of geriatrics in a medical school. He is also Brookdale professor of geriatrics and adult development at the medical school and director of the Gerald and May Ellen Ritter Department of Geriatrics and Adult Development at the Mount Sinai Hospital.

Robert L. Ringler has been named Acting Director, NIA.

CONFERENCES AND WORKSHOPS

SENILE DEMENTIA OF THE ALZHEIMER'S TYPE: ETHICAL AND LEGAL ISSUES RELATED TO INFORMED CONSENT

In November 1981, the NIA convened a conference to address the complex issues related to informed consent for research on senile dementia of the Alzheimer's type.

A task force composed of conference participants has been formed to review the proceedings and develop guidelines to assist investigators in developing protocols for research on this disease.

POPULATION AGING: SOME CONSEQUENCES FOR SOCIAL INSTITUTIONS AND HUMAN SERVICE ORGANIZATIONS

The NIA sponsored a conference in May 1982 in cooperation with the American Council of Life Insurance to focus attention on population aging in the United States and to explore the impact of the most important demograhic trends expected during the next 50 years.

CHANGING WORK ROLES AND AGING WORKERS

The NIA held workshops in May and September 1982 to examine the interplay between changing work roles and aging workers. The meetings focused on technological changes in work and their impact upon work roles, aging, and human performance. The first meeting emphasized gender differences, while the second concentrated on social class differences in these complex interactive processes. Another component of the changing work role, the introduction of wellness programs, is also under scrutiny. Additional followup meetings are planned for the coming year.

INDEPENDENT LIVING IN THE HOUSEHOLD

New research is needed to add to the growing body of knowledge about how particular health behaviors and attitudes of older people are influenced by features of their living conditions. Such variables range from attitudes of relatives, neighbors, and health care practitioners to the availability of improved prostheses, special environmental designs, wellness clinics, and other community supports. In September 1982, the NIA sponsored a workshop to identify conditions that can sustain the health, well-being, and independence of the very old, and to discuss means of reversing disabilities when they occur.

RESEARCH ADVANCES

NIA GRANTEE FINDS EVIDENCE OF UNUSUAL LIFE FORM

The quest for an understanding of what causes Alzheimer's disease continues with studies on central nervous system (CNS) diseases believed to be caused by slow-acting transmissible viruses.

For several years, scrapie, a CNS disease that affects sheep, has provided a tantalizing model for the study of dementing disorders in humans, including Alzheimer's disease. Scrapie is similar to kuru and Creutzfeldt-Jakob disease, two rare diseases which cause progressive, irreversible dementia in humans. This fact, plus the well-established evidence that scrapie is the result of a slow-acting infectious agent, encouraged a new avenue of research on the possible causes of CNS disease in humans.

Scientists pursuing this line of research, however, have consistently failed in their efforts to identify and isolate any component of the infectious agent. Recent research at the University of California at San Francisco suggests that a protein is the life force of the scrapie agent. NIA grantee Stanley B. Prusiner finds that victims of scrapie are infected by what he calls a small proteinaceous infectious particle, or "prion."

Prions have many properties which distinguish them from typical viruses. Although viruses contain nucleic acids, which carry all of the information necessary for the virus to multiply and spread infection, prions may or may not contain a tiny nucleic acid. Even if prions are found to contain a nucleic acid, the scrapie infecting agent would still differ from a virus because the nucleic acid hidden in prions would be too small to accomplish the task of passing on genetic material.

Prusiner's work remains to be confirmed, but if it is, it might significantly alter our understanding of CNS degenerative disorders such as Alzheimer's disease.

FREE RADICAL REACTIONS MAY CONTRIBUTE TO IMMUNE SYSTEM DECLINE

Many of the diseases of later life—rheumatoid arthritis, cancer, and serious infections—are thought to occur because immunological responsiveness changes with age. One age-related alteration in the immune system is a decrease in lymphocyte (white blood cell) response to antigens (foreign substances, such as viruses, which may cause disease).

A possible factor contributing to the decline in lymphocyte function is free radical damage. Free radicals are unstable chemical fragments that readily react with—and sometimes damage—other molecules. Some scientists contend that, although free radicals are normally cleared from the body without causing functional damage and some free radical reactions are beneficial, an age-related accumulation of such damage may interfere with the normal functioning of vital cell structures. NIA grant-supported scientists at the University of Nebraska in Lincoln are conducting studies to determine if the age-related decline in the immune system may be partly the result of free radical damage to lymphocytes.

Margaret Heidrick and her colleagues hoped to discover if dietary supplements of an antioxidant—a compound capable of inhibiting free radical reactions—would alter the decline in immune function in old mice. To assess immune function, the investigators measured the development of antibody-forming cells in response to injections of an antigen often used in immunological research. In addition, they measured the rate of accumulation of lipofuscin—a byproduct of free radical damage—in spleen lymphocytes from control mice and mice fed the antioxidant 2-mercaptoethanol (2-ME).

The results showed that the mice receiving 2-ME had an enhanced immune function at a time when their immune systems would be expected to be least efficient (early life and old age). Also, the rate of accumulation of lipofuscin was slower in lymphocytes from mice receiving the 2-ME diets, suggesting that 2-ME did, in fact, retard the action of free radicals. The researchers also observed an increase in the average and median lifespans of the 2-ME-treated mice.

Heidrick concludes that the enhanced immune function and increased lifespan of the treated mice may be due to a reduction in free radical damage by the antioxidant, as demonstrated by the slower accumulation of lipofuscin.

Although the significance of these findings to humans has yet to be determined, it is possible that, in the future, the use of antioxidants may be able to enhance immune function and thus reduce the degree of illness in the elderly.

NIA SCIENTISTS LOOK AT NORMAL BRAIN AGING

Glucose metabolism is one of three major interconnected measures of brain activity—the other two being brain blood flow and oxygen consumption. New noninvasive machinery which ties X-ray technology to computer technology allows simple tests of glucose metabolism that provide a direct measure of activity in any given brain region. Intramural scientists have used PET scanning and this line of reasoning to come up with some fascinating findings about the workings of the aging brain.

Using PET to scan the normal aging brain, NIA investigators Ranjan Duara and his associates have found no significant age-related alterations in brain glucose metabolism. The scientists tested 40 men, aged 21 to 83, and found this was true for the several dozen regions of the brains that they scanned. These studies suggest that the healthy aged brain is as active and efficient as the healthy young brain.

Of current interest to the investigators is why their findings are inconsistent with changes known to take place in the size and weight (i.e., the number of cells) of the brain as it ages, as well as the findings of other investigators who have reported drops in glucose metabolism with age. The discrepancy might be explained by the conditions of the study. Subjects were tested under resting conditions with their eyes covered and their ears plugged. This could mean that declines in vision and/or hearing are responsible for changes in the levels of brain activity that some investigators have attributed to brain aging. It could also mean that the developing human brain acquires more cells than it will ever need. Therefore, even after the aging brain has lost some 10 percent of its cells, and as much as 50 percent in some vital regions, there are still more than enough surviving cells to power the unchallenged aged brain.

Future studies by Duara and his colleagues will continue to build upon and analyze the results of this work. In the meantime, the investigators' findings are beginning to provide age-related normal values for glucose metabolism in the brains of healthy men of all ages.

RESEARCH LINKS TWO LEADING THEORIES ON ALZHEIMER'S DISEASE

A major new finding has linked the results of two separate avenues of research on Alzheimer's disease: Research that suggests that aluminum may contribute to the disease's development, and research that probes the excess incidence of dementia in three separate populations.

In a decade marked by major advances in the fields of neuroscience and aging research, scientists have employed a variety of methods to investigate the possible cause(s) of Alzheimer's disease. They have looked at the roles of heredity, trace metals, deleterious changes in brain chemistry, and slow-acting viruses, as well as the effect of changes in the aging immune system. This latest finding focuses on the hallmark of Alzheimer's disease, the presence of tangled fibers in the victims' brain cells.

With NIA grant support, Daniel P. Perl of the University of Vermont in Burlington has extended his earlier findings of accumulations of aluminum within the affected brain cells of subjects showing the classic neurofibrillary tangles of Alzheimer's dementia. Perl and a group of colleagues from the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) now report high accumulations of aluminum, iron, and calcium in the brains of Chamoro natives of Guam who have died of amyotrophic lateral sclerosis (ALS) or parkinsonism-dementia. This population is adversely affected by these two chronic disorders, both of which were previously suspected to be transmitted by a slow-acting virus. For several years, however, NINCDS scientists have been studying the possible implications of Guam's environmental deficiency in calcium and magnesium and excess of aluminum and other metals.

Researchers have kept a watchful eye on studies in Guam because of the similarities between the parkinsonism-dementia syndrome and the presenile form of Alzheimer's dementia. In both disorders, there is an excessive accumulation of neurofibrillary tangles in the brains of victims that is associated with severe dementia and death.

These latest findings reconfirm Perl's earlier work in support of studies linking high concentrations of aluminum in the brain to the development of neurofibrillary tangles. They also lend support to a developing hypothesis that environmental factors may be an underlying cause of the ALS and dementia so prevalent in Guam.

Samples of garden soil and drinking water in Guam, as well as in parts of Japan and New Guinea that are similarly plagued by high incidences of ALS and dementia, indicate low levels of calcium and magnesium and unusually high levels of aluminum. Scientists have never been able to prove that aluminum alone predisposes a person to, or causes, Alzheimer's disease.

Aluminum, after all, is one of the most abundant of the earth's elements; it is in the air we breath, in the soil in which foods are grown, as well as in certain commercial products. It may be that high intake of aluminum over a long period of time, coupled with chronic low intake of vital minerals such as calcium and magnesium, ultimately results in a breakdown of the normal mechanisms which metabolize minerals. This, in turn, could result in what investigators find are toxic levels of these elements in brain cells and in the walls of major blood vessels in the brain.

Scientists have yet to determine how or why low levels of calcium and magnesium can lead to high levels of these elements in the brain, but clearly there is a link since the same phenomenon occurs in three different high incidence areas. Perhaps the body is overcompensating for the lack of vital minerals by storing these in combination with other available trace elements in the bones which ultimately leads to deposits in central nervous system tissue.

Future studies will determine whether accumulations of metals in the brain are a primary cause of Alzheimer's disease or if other factors or circumstances might combine with environmental factors to trigger the onset of chronic, and ultimately fatal, diseases of the nervous system.

INVESTIGATOR REVEALS NEW CLUE TO THE MECHANISMS OF ALZHEIMER'S DISEASE

Another impotant study on the characteristic nerve cell changes associated with Alzheimer's disease has revealed some unusual and unexpected findings.

For several years, Dennis Selkoe, a neuropathologist and neurologist at the McLean Hospital in Belmont, Mass., has received NIA grant support for his studies on the role and chemical composition of elements in normal and abnormal brain cells. Much of his work has focused on neurofilaments, components of the cell that are made up of long hair-like strands of protein. In Alzheimer's disease, proteins like these bind together and twist into spiral-like configurations called paired helical filaments (PHF). Masses of PHF's form the characteristic neurofibrillary tangles of Alzheimer's disease. It is possible that these changes can be linked to cell death.

Selkoe and his colleagues have found that the proteins in Alzheimer's tissue are highly resistant to standard protein solvents and that the molecules of the PHF's bind tightly together to form an extremely rigid "cross-linked" structure. The investigators discovered these unique traits after conducting numerous tests using various methods which had consistently suggested that virtually all proteins in Alzheimer's tissue were similar to proteins in healthy aged brain tissue. Finally, after some 2 years of testing, Selkoe and his colleagues concluded that the proteins of the PHFs were bound in a configuration that was immune to both standard and extraordinary methods of breakdown and analysis.

This is not the first time that cross-linking has been observed in aging human tissue. Other examples include the changes that take place in the formation of cataracts. In their most recent studies, Selkoe and his colleagues have compared the mechanisms responsible for cross-linkage in the lens of the aging eye to what may be going on in the aging brain. In the lens, an enzyme called transgultaminase appears responsible for the binding. Selkoe has recently completed studies marking the presence of this enzyme in the human brain. Furthermore, the investigators have experimentally induced the development of a rigid molecular structure—although different in form from the PHF—by adding the enzyme to normal neurofilaments. Future studies will look for an examine other similarities between cross-linking in the lens and in the brain and attempt to find out what causes the formation of structures that irreversibly alter brain cells and play a major role in Alzheimer's disease.

CLUES TO NERVE DAMAGE IN DIABETES FOUND

Diabetes mellitus is one of the most common chronic diseases diagnosed in the elderly. A frequent complication of diabetes is nerve damage, especially in the legs and feet. Understanding how and why this damage occurs is a goal of the research being conducted by NIA grantee Helen Vlassara at the Rockefeller University in New York.

It has been shown previously that in diabetic individuals a process know as nonenzymatic glycosylation (the attachment of glucose to body proteins causing functional alterations) occurs in proteins in the blood (hemoglobin and albumin) and in the eye. Vlassara and her colleagues are examining the possibility that nonenzymatic glycosylation may also occur in the peripheral nervous system, in tissues of the feet and legs where degeneration characteristically develops.

In damaged nerves of diabetic individuals, the most significant structural change is patchy demyelination, loss of or damage to the myelin sheaths surrounding the nerves. Damage to the nerve sheath reduces the speed with which nerve signals travel from the brain to the target muscles, accounting for the loss of sensation and function in these muscles. Vlassara's animal studies suggest that an accumulation of glycosylation products may act as a signal which initiates this demyelination. This work will be extended to nervous system tissues from diabetic and age-matched control subjects, with the hope that a more complete understanding of the pathway for nerve damage may result in measures to avoid many of the devastating complications of diabetes.

NEW DIAGNOSTIC STANDARDS FOR OBESITY AND DIABETES DEVELOPED

Diabetes mellitus and obesity are two disorders which have much in common, including their increasing prevalence with age. Both disorders are associated with higher incidence rates of heart disease, hypertension, and other diseases, as well as with higher death rates. There is also a strong link between obesity and the development of the noninsulin-dependent type of diabetes.

Scientists have questioned the diagnostic standards used to separate the disease state of both conditions from the normal state. At what point, for instance, does weight relative to height become abnormal and potentially harmful? When does blood sugar reach dangerous levels? As a result of intramural research in these areas done at the NIA's Gerontology Research Center (GRC) in Baltimore, new standards to define normal body weight and blood sugar levels have been proposed.

Until recently, up to 50 percent of people aged 60 and older were at risk of being diagnosed as having diabetes mellitus largely because their blood sugar levels measured by the glucose tolerance test were above those normally shown by younger adults, rather than because of known adverse effects of these elevated blood sugar levels.

Data collected from subjects in the Baltimore Longitudinal Study of Aging (BLSA) and other populations show that within broad limits, some degree of elevation of blood sugar levels seems to be a normal part of the aging process and does not represent a disease state. Therefore, Reubin Andres and his colleagues in the GRC proposed new standards for interpreting glucose tolerance test results in middle-aged and older adults. Subsequently, the standards of abnormality have been greatly increased by the NIH National Diabetes Data Group. As a result, the number of falsely positive interpretations of the glucose tolerance test have been substantially reduced in middle-aged and older people.

To determine obesity, scientists and physicians often use a height-weight chart that was developed by the insurance industry in 1959. At the time, only that industry had examined the association between obesity and survival. Recently, however, many additional studies have been published.

Andres and his colleagues reviewed over 40 studies of diverse populations in the United States and other countries. In almost all of the reports, death rates were highest among both very lean and very obese people. The lowest mortality in almost all groups, including the BLSA subjects, occurred in people of average or above-average weight. Although there are many known adverse effects of even moderate obesity, these seem to be balanced by some unknown beneficial effect of obesity on survival.

Since there are more cigarette smokers among the thin than among the more obese groups, the scientists studying the BLSA and several other populations looked at death rates among smokers and nonsmokers separately. They found that mortality in both groups was higher among the smokers than among the nonsmokers, but mortality was lowest among average or above average weight people.

Decisions about individual ideal weight depend on many factors, including general health status, the presence of specific diseases, and family history. However, experts are beginning to believe that, in general, standards for healthy weights may be somewhat higher than was previously thought.

DIET-RESTRICTED RATS PERFORM BETTER PHYSICALLY AND MENTALLY

Investigators at the GRC and in other research institutions have reported for many years that some strains of rats and mice live considerably longer when their diets are restricted, either by feeding them every other day or by reducing their calorie and/or protein levels each day. Recent studies at the GRC with diet-restricted rats show that they not only live longer, but in some ways are smarter and healthier than rodents allowed to eat freely.

To assess intellectual functioning, the late Charles L. Goodrick and intramural scientist Stephen P. Tzankoff tested rats on complex mazes. Rats with experimentally extended lifespans learned the mazes about as well as young rats, and much better than aged rats who were fed freely, even though the diet-restricted rodents were older than the freely fed aged animals.

Other GRC researchers have looked at how dietary restriction alters the number of receptors for dopamine, a neurotransmitter that affects motion. As discussed in the "Special Report on Aging 1982," they found that aged food-restricted rats has almost as many of these receptors receptors as young rats and many more than old rats fed freely. In recent research to determine what effect this might have on behavior, James A. Joseph, Donald K. Ingram, and George S. Roth injected the animals with a dopamine-like drug to stimulate dopamine receptors. The more the receptors were stimulated, the more the rats made certain movements. The older freely fed rats responded very little, whereas the older food-restricted animals and the young animals were equally responsive.

The investigators also assessed kidney function among the groups of rats, since impaired kidney function is a major cause of death for old rats. Goodrick and Tzankoff found that the kidney function of the diet-restricted animals was similar to that of yound rats and much better than that of freely fed older rats.

Many factors can account for the increased longevity and apparently better health and functioning of diet-restricted rodents. The amount of increase in lifespan differs with the strain of rodent, how early in life food restriction is begun, and other variables, showing that genetic factors play an important role.

Scientists have also been looking at how body weight might affect longevity in diet-restricted animals. Although as a group, diet-restricted rats had lower body weights than rodents fed freely, within each group, it was the slightly heavier animals who lived longest. This is consistent with findings in human populations (see section entitled "New Diagnostic Standards for Obesity and Diabetes Developed") which suggest that the mildly obese live longer.

Another hypothesis is that since diet-restricted rodents take longer to reach maturity, this extended period of growth might be an important factor contributing to their longevity. However, recent studies at the GRC, which show that some strains of rodents live longer even when dietary restriction is begun at maturity, have cast doubt on this theory.

Scientists now wonder if the explanation for the dramatic effects of dietary restriction might lie within the immune system. They are continuing to investigate this and other body systems for clues as to how and why reducing food consumption can lengthen life and improve health in some animals.

EXERCISE ALTERS BODY COMPOSITION AND LOWERS BLOOD SUGAR LEVELS

Along with public interest in physical fitness, there is much research interest in long-term exercise as a possible means to prevent or alleviate some of the diseases and disabilities of old age. It is not yet clear whether exercise, carried out on a regular basis, will affect the process of aging itself. Nevertheless, some scientists believe that exercise can lead to a slowing of the age-related physical decline brought on by certain diseases and lifestyles. One such investigator is John O. Holloszy at Washington University in St. Louis. Holloszy feels that participation in a regular, moderate exercise program may have a beneficial effect on the heart and lungs, help keep body fat down, increase glucose (sugar) tolerance, reduce the risk of coronary artery disease, and in some cases aid sleep and even alleviate depression.

Holloszy's studies of exercise, supported by a research grant from the NIA, have corroborated some earlier findings about exercise and yielded important insights into certain aging processes.

Holloszy is evaluating the effects of long-term, regularly performed exercise on longevity in the rat to determine which types of illness are more common in sedentary rats, and if causes of death differ in active and inactive animals. He is finding that regularly performed, moderate exercise can prolong rats' lives. But more research must be done before any conclusions can be drawn about types of illness and causes of death in exercising versus sedentary animals.

Holloszy is also looking at the effects of aging and exercise on muscles, blood sugar levels, and body composition. His studies have reconfirmed the fact that there is a progressive change in body composition with age. In rats, as in humans, there is a gradual loss of lean body tissue and an increase in body fat with age. Holloszy has discovered, however, that lean tissue declines at a slower rate in rats that exercise. Furthemore, exercise may be more effective than dietary restriction in controlling body fat in older animals. Rats living on restricted diets and not exercising had more body fat than exercised rats given unlimited access to food.

Another finding by Holloszy is that the number of fat cells increases in older rats. This is contrary to earlier reports by other scientists that the number of fat cells is fixed early in life. In this study, the number of fat cells was highest at 28 months (late life for a rat).

Holloszy also compared sensitivity to insulin and the rate at which skeletal muscles take up glucose in young and old rats. (Insulin is the hormone that enables the body to use glucose properly.) He found that the rate at which skeletal muscles take up glucose was not significantly different in 24-month-old rats than in 9-month-old ones, providing evidence that insulin sensitivity need not deteriorate with age. He then compared glucose uptake in freely eating rats that exercised, freely eating rats that were sedentary, and sedentary rats whose diets were controlled so that their weight was the same as that of the exercisers. He found that glucose uptake by skeletal muscle was significantly higher in the exercisers than in the sedentary freely eating rats, but not than in the diet-restricted sedentary rats. Thus, exercise and weight play an important role in the body's ability to handle sugar.

Glucose uptake by fat cells and their sensitivity to insulin also were studied. Holloszy found that the fat cells of the freely eating sedentary rats were large and extremely resistant to insulin. In contrast, the fat cells of the exercisers were small and highly sensitive to insulin. The fat cells of the diet-restricted sedentary rats were intermediate in size and sensitivity to insulin. Holloszy again showed that age was not a factor in fat cells sensitivity in insulin. Rather, the sensitivity varied according to the size of the fat cells, which appeared to be influenced by exercise. Interestingly, the study also found that fat cells of the 24-month-old exercisers were as small as those of the 9-month-old exercisers, even though the former engaged in only one-fourth as much activity.

Holloszy's findings suggest that exercise may help control weight and possibly protect against adult-onset diabetes, which can be triggered by obesity in individuals who are genetically predisposed to this disorder.

PROJECT PROBES LITERATURE TO ASSESS ELDERLY'S NEEDS FOR SIX VITAMINS AND MINERALS

Five panels of experts have analyzed the scientific literature on calcium, vitamin D, iron, zinc, folate, and thiamine in an effort to determine the elderly's requirements for these nutrients. The six vitamins and minerals were chosen because they are known to be associated with specific disorders that are common among older people. By more closely gauging their needs for these nutrients and perhaps suggesting dietary and other changes, it may be possible to minimize the occurrence or severity of certain disorders.

The project was conducted by the American Society for Clinical Nutrition in Bethesda, Md., under a conference grant awarded by the NIA. Richard S. Rivlin of the Memorial Sloan-Kettering Cancer Center in New York and Eleanor A. Young of the University of Texas Health Science Center in San Antonio codirected the study.

For each nutrient, a panel of four experts reviewed the existing scientific literature, discussed and evaluated the data, and then developed a consensus statement. They looked at the dietary intake of the nutrients in the elderly population of the United States, the dietary requirements of the elderly, and the association of inadequate intake with specific diseases. Gaps in scientific knowledge were identified, providing direction for future research.

The panel investigating calcium found that many older people may not be getting enough of this mineral in their diets. A deficiency of calcium is one factor which may lead to thinning of the bones and fractures of the hip, spine, and other weight-bearing parts of the skeleton. This condition, called osteoporosis, is responsible for much suffering and disability among the elderly, especially women.

Beginning at about age 40, the body's ability to absorb calcium starts to decline. In addition, older people tend to decrease their consumption of calcium-rich foods such as milk, cheese, and ice cream. Decreased levels of physical activity aggravate the situation further, since exercise favors bone renewal. Women face an additional risk of osteoporosis, since the drop in estrogen levels following menopause also affects bone metabolism.

Another panel of scientists found that most elderly people have adequate vitamin D levels, but that those who are ill or who live in institutions may have deficiencies. Vitamin D is needed along with calcium to maintain healthy bones, and the requirement increases with age. This nutrient is supplied by foods such as vitamin-fortified milk, liver, eggs, and saltwater fish. In addition, it is formed in the skin following exposure to sunlight. Absorption of vitamin D declines with age and many older people cannot get out in the sun (or choose to avoid it).

A third panel studied iron, which is necessary for transporting oxygen to body cells and for the cells' utilization of oxygen. An inadequate level of this mineral results in iron deficiency anemia. The panel found that iron generally is obtained in adequate amounts by most elderly people. The body's requirement for iron is no greater in the elderly than in young adult men, and is less than in children and menstruating women. Therefore, such deficiencies are much more likely to be found in children and young women than among older people.

Another panel found that dietary intake of zinc among some older people may be less than desirable, but the data supporting this impression are limited. This mineral is essential for many metabolic processes, the functioning of enzymes, and DNA synthesis. Insufficient intake of zinc can impair wound healing and immune response.

Folate was studied because a deficiency can lead to anemia. The panel investigating this vitamin did not find evidence that dietary folate deficiency is a major contributor to the problem of anemia in the elderly except among hospital patients, those taking certain drugs, and alcoholics. The consensus was that the average dietary intake of folate in the elderly population living independently is probably adequate, with the possible exception of those who are poor. Although further study is needed, no evidence was found that the folate requirements of the elderly are either higher or lower than those of younger adults.

Thiamine (vitamin B_1) is necessary for a healthy nervous system. Deficiencies are associated with degenerative neurological disorders and heart disease. This nutrient, according to the investigators, appears to be generally adequate in the diets of most older Americans. However, alcoholism interferes with the absorption of thiamine, and severe disease and poverty adversely affect dietary intake of this vitamin.

The panel members pointed to chronic illness and the use of certain drugs as major contributors to nutritional deficiencies among the elderly. These factors often interfere with the ability to eat and absorb the foods needed for good nutrition. Alcoholism also was cited as a major cause of thiamine and folate deficiencies.

The investigators said that it is difficult to evaluate nutritional status in the elderly because of a lack of information about their specific needs as compared to those of younger people. Few studies of nutrient requirements have been done in the very old. There also is a great need for more effective techniques to detect deficiencies in the elderly.

Although their findings apply to most older people, the experts caution that certain segments of the population are more likely to have deficiencies than others. These include the sick, the poor, those who live in institutions, and alcoholics.

Nutrition throughout the lifespan has a profound effect on health in the later years, and diet is one health factor that people can control. The results of this study should help physicians, dietitians, and other caregivers to offer better nutritional guidelines so that some disorders of later life can be minimized.

STUDY OF HEALTHY ELDERLY YIELDS INFORMATION ABOUT THEIR NUTRITIONAL STATUS AND NEEDS

In a comprehensive study that promises to help clarify the special nutritional needs of the elderly, James S. Goodwin at the University of new Mexico in Albuquerque is examining the nutritional status of 270 healthy people aged 60 and over. The 5-year project is supported by a research grant from the NIA. Goodwin's study is designed to determine the consequences of subclinical malnutrition (deficiencies that do not cause obvious symptons) in healthy people in terms of subsequent illness. The research also seeks to find out whether or not nutritional deficiencies correlate with the decreasing ability with age to resist disease.

As part of the study, Goodwin is gathering information about the dietary habits of the volunteers, all of whom are free of major illness, take no prescription drugs, and live independently in the community. The participants are generally knowledgeable about nutrition and they can afford to buy a variety of foods. Sixty percent regularly take one or more vitamin and/or mineral supplements.

The data gathered thus far indicate that the diets of this group of people are generally adequate, except for intakes of calcium[1] and Vitamin D among the women. Sixty-seven percent of the women consume less than the recommended dietary allowance (RDA) for calcium and 54 percent get less than the RDA for vitamin D. Goodwin also found that blood levels of vitamin D are very low in the volunteers.

Vitamin D is required for the absorption of calcium by the body, and thus is important for maintaining healthy bones and preventing osteomalacia, a softening of bone. A deficiency of vitamin D may also play a role in osteoporosis.

Goodwin blames low consumption of dairy products, especially vitamin D-fortified milk, and insufficient exposure to sunlight for the calcium and vitamin D deficiencies. He says it is somewhat surprising that people who live in a warm, sunny climate such as that of New Mexico have inadequate levels of vitamin D. He thinks that many elderly people who live there are avoiding the sun to reduce their risk of skin cancer, while at the same time cutting down on vitamin D-containing foods such as milk and eggs to lower their fat and cholesterol intakes. Other factors, such as a decreased ability to absorb the vitamin, could be responsible as well. If older people cannot get more vitamin D from foods or more sun exposure, a daily supplement may be advisable, Goodwin concludes.

An evaluation of vitamin C status in the volunteers revealed that less than 2 percent are in danger of developing clinical deficiencies. Generally, the dietary intake of vitamin C is high (about 2.4 times the RDA) and more than half the volunteers take supplemental vitamin C as well. Men and women consume about the same amounts of vitamin C in their diets and take almost equal amounts in supplement form. The study found, however, that men need twice as much vitamin C as women do to maintain optimal blood levels of the vitamin. Goodwin suggests, therefore, that different RDA's for vitamin C are needed for men and women. He proposes that elderly women need 75 mg per day, while older men require 150 mg. (The current RDA for men and women over age 51 is 60 mg.) Vitamin C supplements, Goodwin found, do not significantly raise the total level of this vitamin in the body when dietary intakes are adequate. The excess vitamin C is excreted in the urine.

Goodwin also analyzed riboflavin (vitamin B_2) intakes in the study population. Although the women get significantly smaller amounts of riboflavin in their diets than do the men, both have adequate intakes. Regardless of the use of supplements, older people of both sexes have increasingly higher riboflavin levels with age. Younger adults, the study indicated, have a greater risk of riboflavin deficiency than do older ones.

Many of the volunteers in the study take megadose supplements of vitamins and/or minerals (defined as at least five times the RDA). The most popular supplements are vitamins C and E. Because of preliminary reports from several researchers that certain vitamins, taken at doses above the RDA, may have a beneficial effect on resistance to infections and cancer, Goodwin decided to assess the effect of megadose vitamins and minerals on the immune system. He compared the immunological functions of the volunteers who are taking large amounts of specific nutrients to those of others not taking them, and found that the megavitamins have very little effect. This finding suggests that, although other scientists may have noted a temporary rise in immune response following short-term trials of megavitamins, this effect is not a lasting one.

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[1] A panel of experts who examined the scientific literature related to calcium status in the elderly recently reached the same conclusion. See section entitled "Project Probes Literature to Assess Elderly's Needs for Six Vitamins and Minerals."

This study of nutrition among healthy elderly people already has produced important information about their nutritional status and needs, and more findings are expected within the remaining 2 years of the project.

LANGUAGE: A NEW CLUE TO ALZHEIMER'S DISEASE

General difficulties in language usage and comprehension have always been included among the symptoms of Alzheimer's disease and other irreversible dementias. Now, an NIA-supported research scientist finds that specific language problems can be used to distinguish and diagnose particular forms of dementia.

The recommended examination of an older person complaining of memory loss and confusion includes a battery of physical and neurological tests as well as certain psychological tests to detect or monitor declining skills. Commonly used tests can quickly evaluate a person's sense of time, place, and self. They can also assess short-term memory as well as the person's skills at completing simple mathematical calculations. Declines in these skills are among the first clinical signs of Alzheimer's disease. More and more, however, mental status tests include questions aimed at evaluating linguistic skills. A patient will be asked to name objects, exhibit comprehension of a spoken or written statement, or write a spontaneous sentence.

Kathryn Bayles, an NIA grantee at the University of Arizona in Tucson, has found that by asking subjects to name common household or everyday objects—such as a broom, a purse, an apple, or a telephone—an examiner can easily differentiate between moderately impaired Alzheimer's patients and healthy older individuals, and in some instances can detect mild cases of Alzheimer's disease. Such demands can uncover the subtle, but serious, deficiencies often masked by the residual social skills of an Alzheimer's patient in the early and middle stages of the disease.

Bayles' study is one of several that are looking at the language skills of healthy aged adults and what happens to these skills when subjects suffer from Alzheimer's disease, Huntington's disease, Parkinson's disease, or multi-infarct dementia. Her results confirm that patients in all stages of dementia have difficulties expressing themselves, but also suggest that tests of language skills are sometimes more sensitive to the presence of dementia than are certain psychological tests. Although her studies are not yet completed, it appears that the deterioration of language skills is more severe and more rapid in Alzheimer's disease than in other forms of irreversible dementia.

As this study progresses, Bayles and her colleagues hope to develop a standard against which clinicians can measure the verbal performance of their patients. According to Bayles, tests of linguistic skills might be refined to determine the presence and severity of senile dementia and to outline interventions that might improve comprehension. She has already found a certain logic in the incorrect responses given by Alzheimer's patients: moderately affected patients who cannot name a given object often will substitute a word which describes the object or the name of a similar object. At the very least, such studies can provide valuable information on the best methods for communicating with patients over the course of a disease which progressively limits communication.

STUDY DISPUTES YET ANOTHER AGE-RELATED DEFICIT

Research on aging has questioned and debunked a number of mistaken beliefs about aging, but few have remained as firmly entrenched as the concept that reaction time slows with age. Now, research is beginning to suggest that even that deficit, to whatever extent it may exist, can be overcome.

By setting up a test that, in effect, introduces characteristics of real-life jobs into the laboratory, NIA grantee Alan Baron is showing that increased time pressure has little or no effect on the performance of routine, even if complex, activities by older people.

At the University of Wisconisn-Milwaukee, Baron and his colleagues have developed two sets of complex tasks which are completed by paid subjects who report to the laboratory much as they might to a part-time job. One set of tasks acquisition of new information; the other tests performance. Healthy old and young subjects were asked to complete either an acquisition sequence or a performance sequence several times, with less and less time allowed to complete the tasks. The major difference was that in the acquisition sequence, volunteers were faced with new tasks and demands and less time with each successive session; in the performance sequence, volunteers were given less time to respond to demands and tasks that never changed.

While the young volunteers were unaffected by the amount of time they were given to complete each sequence, the performance of their older counterparts was considerably disrupted, particularly when they were faced with new situations as in the acquisition sequence. When the situations required a familiar response, however, time made little difference.

Even on tests on learning, Baron and his colleagues found that they could improve a subject's responses by using operant conditioning techniques to reinforce rapid learning and efficient performance. One way they did this was by paying to research subjects for correct, and quick, responses.

Scientist have long speculated that laboratory tests of learning, memory, and intelligence do not give older individuals the full benefit of their years of accumulated wisdom and experience, and that older subjects may lack motivation and familiarity with the testing situation. Baron's work, which will be expanded in future years, begins to suggest that experience with a situation of activity can be an important factor in making complex decisions. Perhaps more significantly, this study shows that older people are also capable of being trained or motivated to learn new information within the time constraints that may be made on the job.

BEHAVIORAL TRAINING TECHNIQUES CAN REDUCE HIGH BLOOD PRESSURE

High blood pressure (HBP), or hypertension, affects about 60 million people in the United States. Untreated, HBP can lead to other serious problems including stroke, heart disease, and kidney failure. HBP can be successfully treated with drugs; however, these medicines can also cause unwanted side effects.

NIA scientists Bernard Engel, Michael Glasgow, and Kenneth Gaarder have shown that patients with borderline HBP can markedly reduce their blood pressure using behavioral techniques. In a series of studies with 127 patients whose diastolic blood pressures were between 95 and 105 mm Hg (millimeters of mercury), the researchers found that patients who measured their own blood pressures daily and had monthly review and assessment with a health professional achieved a significant drop in blood pressure. Relaxation training and systolic blood pressure biofeedback further improved blood pressures. (In biofeedback, data obtained from a specific body function—in this case, sounds in the arteries—are given back to the subject through visual or auditory displays.) In the long term, a combination or relaxation and biofeedback and better results than either technique used alone. Followup studies showed that these reductions in blood pressure could be maintained for at least 18 months.

Some of the patients in these studies were taking diuretics (medications to increase urine output), but no other antihypertensive drugs were used. While the behavioral treatment seemed most effective for those not taking diuretics, several patients who discontinued diruetic therapy were able to sustain their reductions in blood pressure.

The researchers suggest that these procedures, which can be applied in an office or outpatient setting, can reduce the need to use antihypertensive drugs in patients with borderline HBP.

EPIDEMIOLOGIC STUDIES YIELD NEW INFORMATION ON HEALTH AND LONGEVITY

Life expectancy has climbed to 73.7 years for people born in 1979. In 1890, only 4 percent of the population lived past 65 years; today, 76 percent will live well beyond that age. Is illness-particularly the final illness, which tends to be expensive-being postponed? Or are the added years marred by bereavement and painful, limiting diseases and disabilities?

Under the direction of Jacob A. Brody, scientists at the NIA have examined data from the National Center for Health Statistics (NCHS) on illness and death for the period between 1900 and 1978. Although many experts in aging research believe that increased life expectancy reflects a reduction in disability and disease, the NIA researchers have found that a far more complex situation exists.

Their analysis showed that illness is generally not being postponed, and that disability appears to be increasing at all ages. The number of people reporting peremanent limitions in their activities for health reasons reached 30.2 million in 1976, a 37-percent increase since 1966. Heart conditions, cancer, diabetes, hypertension, and visual and hearing impairments are the ranking contributors to this increase in disability. Rates of illness, particularly chronic illness, are increasing most rapidly among the group aged 45 to 64. By age 65, then many people have well-established illnesses. Since the fastest-growing population group is that aged 75 and over—whose members are very likely to become ill—the pressure is intense to understand how chronic diseases develop and how to eliminate or combat them effectively.

Cancer is often thought to be directly related to aging, as most cases occur in the older age groups. Some experts hypothesize that the very process of aging contributes to the onset of cancer. However, the NIA analysis of NCHS data showed that cancer deaths peak at about 65 and then level off around age 80, after which they continue to rise at a modest rate of about 1 percent per year. At ages 65 to 69, cancers account for about 30 percent of all deaths, whereas by age 80 they account for only 12 percent of deaths. The relationship of cancer and aging is by no means as direct as was once thought. The advanced aging process may actually protect one against cancer, if, as some scientists theorize, cellular mutations are expressed more slowly or are more difficult to induce in the elderly.

Cardiovascular disease rates rise continuously with age, accounting for 50 percent of the deaths in the 65-to-69 age group and 69 percent of the deaths in the group aged 80 and older. Although there has been a striking decline in deaths due to cardiovascular disease, it remains the major cause of death in the elderly.

The NIA researchers caution that looking at specific diseases may obscure an accurate overall picture of the later years. Simply assuming that cardiovascular disease is being attacked successfully may lead to a conclusion that people are living healthier and longer lives. The reality may be that death is only delayed while illness occurs at the same ages as in the past, with result that people are sick for longer periods of time. An age-sensitive analysis of disease patterns such as this one can yield important information of illness over the life cycle and point the way toward preventive health practices.

HEALTH CONSEQUENCES OF RETIREMENT STUDIED

It has been widely believed that retirement has an adverse effect on physical and mental health. This popular notion is being challenged by studies that examine why, and under what conditions, health may improve or worsen once a person retires from work. Evidence is building which suggests that retirement has only a minimal effect on health.

In one investigation, NIA grantees Raymond Bossé and David J. Ekerdt, at the Veterans Administration Outpatient Clinic in Boston, compared changes in physical health between 260 men who retired and 500 of their working peers over a 3-year period between 1975 and 1978. The researchers found that, although some individuals in both groups reported health declines, workers who retired experienced no more declines in health than those who continued to work. Even those who were subject to mandatory retirement did not have a higher number of health complaints, although mandatory retirement is often thought to be more stressful than voluntary retirement.

When asked to describe how retirement affected their health, 38 percent of the retirees reported a "good" effect. The investigators attribute this partly to more relaxed lifestyles, particularly since the perception of improved health was more frequent among those retirees whose jobs had been more stressful. Only 2 percent reported that retirement had a "bad" effect on their health.

Men who retired primarily because of illness or disability (24 percent of the sample) differed markedly from those who retired for other reasons. They were less healthy when working then other prospective retirees, often retired early, and were five times more likely to report poor health after retirement. It may be because of the records of these "disability retirees" that retirement is frequently viewed as being associated with declining health.

Although it is often assumed that there are adjustment periods after retirement which may be stressful and cause health problems, the investigators found no particular time within 4 years of retirement when health risks were greater.

These findings should prove useful in understanding the complex issues of retirement and health in later life.

INDEPENDENCE OF ELDERLY LINKED TO CAREGIVERS' ATTITUDES

Research in the behavioral sciences is showing that, even in nursing homes, dependent and unhappy patients can often recover a degree of independence when their daily activities promote self-care, interaction with others, and a sense of control. Routines which stimulate independence can result not only in increased alertness and involvement, but also in improvements in general health.

NIA grantees Eva Kahana and Asuman Kiyak at Wayne State University in Detroit are investigating how attitudes among people who provide services to the elderly in nursing homes and community agencies are related to their behavior toward their older clients and to job satisfaction. Their study suggests that nursing home employees' attitudes toward the elderly largely determine whether they will encourage patients to be dependent or independent. The more favorable the attitudes, the greater the chance that the staff members will promote independence.

Kahana and Kiyak questioned 423 employees of nursing homes and community agencies in Detroit and Seattle on their beliefs and feelings about the elderly and their own aging. The researchers also asked the employees how they would treat older people in certain situations.

Employees who were satisfied with their jobs seemed to like their elderly clients better. These workers also had more positive attitudes toward their own aging and death. Administrators, nurses, those who had some gerontological training, and employees who were older and married were the most satisfied with their work and their supervisors.

Volunteer workers and administrators were the most likely to encourage elderly clients to do things for themselves. Nurses' aides were more prone to reinforce dependence on caregivers and the family. Interestingly, part-time workers were more likely than full-time employees to stimulate independence. Employees on night shifts also tended to promote independence.

The investigators found that employees in community agencies encouraged independence and generally were more positive toward their clients and toward their own aging than employees in nursing homes were. Employees with some training in gerontology had fewer stereotypes about older people and were more likely to encourage their clients to be independent. However, in general, training in gerontology did not seem to affect these workers' attitudes toward the elderly or toward their own aging.

Kahana and Kiyak concluded that seeking nursing home or community service employees who hold positive attitudes toward the aged may be advisable even if their education is limited or if they want to work with elderly clients on a part-time basis. Their findings also suggest that more mature workers are better suited to care of the aged.

SIZE AND NATURE OF OLDER POPULATION PROJECTED

It is important to have accurate predictions about the older population in coming decades in order to anticipate health, economic, and social needs and plan for services. Several NIA grantees are examining the accuracy and utility of death rates and other health statistics in an effort to develop a picture of the changing size of the elderly population, what factors are associated with survival to old age, and the major causes of illness and death.

Eileen M. Crimmins, at the University of Southern California in Los Angeles, has documented declining trends in American death rates and examined the implications of these trends on the size and composition of future elderly populations. Her work involved an analysis of death rates from five major categories of causes of death since 1940: cancer, cardiovascular diseases (diseases of the heart and blood vessels), violence (accidents, murders, and suicides), diseases of infancy, and all other causes.

From 1940 to 1954, decreasing death rates occurred mostly in the younger age ranges and were largely due to control of infections by antibiotics and similar drugs. Death rates changed very little between 1954 and 1968, after which deaths from cardiovascular diseases began to decline dramatically. Because these diseases primarily affect older people, for the first time in history there was a rapid drop in death rates at older ages. Advances in the diagnosis and treatment of chronic diseases as well as socioenvironmental factors (such as exposure to new chemicals, smoking, and changing eating patterns) can be expected to affect longevity in the future.

If current trends continue, we can expect large increases in life expectancy at older ages. Crimmins predicts that by 2000, there will be approximately 35.8 million people over 65. She also projects that in 2000, life expectancy at birth will be 80.4 years (an increase of 7.2 years over life expectancy at birth in 1977), and that people who survive to age 65 will average another 21.8 years of life. She expects that women will continue to outlive men.

At the Duke University Center for Demographic Studies in Durham, N.C., Kenneth G. Manton and his colleagues have developed new methods for analyzing death rates which take into account differences in the risk of developing a chronic disease and in the rates at which chronic diseases progress in individuals.

This new methodology recognizes that death is often due to several diseases rather than to a single cause. Manton's work assesses the relative contributions of different major diseases to death and how these diseases might be treated or cured in the future. For example, progress in the prevention and treatment of atherosclerosis (fatty deposits in the arteries) may prevent or delay deaths from heart disease and stroke. Manton also evaluated how patterns of disease vary with age, race, and sex, and considered how these patterns can be used to predict the future health status of the elderly population. By having a knowledge of disease and death patterns, population researchers can become more sensitive to early signs of population change and better anticipate future developments.

NATIONAL CANCER INSTITUTE

The National Cancer Institute (NCI) funds a wide range of research related to cancer and aging. This includes basic biological studies examining why cancer increases in the elderly, as well as efforts to improve prevention and treatment and to develop support systems for the special problems of the older cancer patient.

Why Cancer Increases in the Elderly

Central to the puzzle of cancer and aging is the possibility that both involve similar body processes. For example, how does the body's natural defense system against disease—the immune system—change in both aging and cancer? Such questions were explored 2 years ago at "Research Frontiers in Aging and Cancer: International Symposium for the 1980's," jointly supported by the NIA, the NCI, and Bankers Life and Casualty Co. Proceedings of that symposium were published as NCI Monograph No. 60 in August 1982.

It is suspected that the immune system functions less efficiently with age and, therefore, plays a part in increased risk of developing cancer. The NCI is supporting research on the interrelationships among cancer, aging, and the immune system. Studies continue to show how complex this relationship is.

Natural killer (NK) cells are a type of white blood cell known to play an important role in defense against cancer cells. Grantee Sudhir Gupta and his associates at Memorial Sloan-Kettering Cancer Center in New York, funded by both the NCI and the NIA, recently showed increased NK cell activity in older compared to younger men, spurring new interest in the role of this immune mechanism in the elderly.

Nutritional status may have effects on the immune system and, in turn, on the development of cancer. A number of animal studies have shown that dietary restriction beginning at an early age extends survival and slows the decreased immune efficiency believed to come with age. With grant support from the NCI and the NIA, Richard Weindruch and associates at the University of California, Los Angeles, have further confirmed that, in animals, dietary restriction (lower total caloric intake) beginning in mid-adulthood can substantially inhibit the slowing of immune efficiency and the development of spontaneous cancer.

NCI epidemiologists also are studying dietary influences and cancer in some retirement communities.

Another key question is whether cancer is a consequence of aging or of exposure(s) to cancer-causing agents. The weight of evidence seems to support the latter, but this also is a complex area, probably involving both factors and, in some cases, heredity as well.

NCI grantee Suresh Moolgavkar and colleagues at the Fox Chase Cancer Center in Philadelphia have developed a mathematical model to compare human breast cancer patterns in various populations, separating out the influence of age from the influence of environmental factors in cancer development. Effects of aging as a factor in cancer development were similar in countries with heterogeneous populations, such as Japan and the United States.

In another study, J. M. Ward and his colleagues at the NCI's Frederick Cancer Research Facility (FCRF) studied cancer development in aging male rats that were free of exposure to chemical cancer-causing agents or pollutants. In the study, a number of cancers, such as prostate, testes, skin, pituitary, and adrenal, occurred in the animals and were related to their age: the older animals developed more cancers than the younger, even under the same environmental conditions. Currently, Ward and his associates are studying the effect of different retinoids (derivatives of vitamin A) on lifespan and cancer incidence in animals.

Both animal and human studies have indicated that skin cancer from the ultraviolet (UV) wavelengths of sunlight is influenced both by UV dose and genetic background. Studies in animals by NCI contractor Margaret Kripke (Litton Bionetics) and visiting scientist Peter Ebbesen (Kraeflforskings, Aarhus, Denmark) working at the FCRF have shown that the properties of the skin and the age of the host also play a role in the development of skin cancers. A complicated array of factors are involved in calculating estimated risks. In the case of sunlight, it is believed that the same process that causes aging in the skin also causes skin cancer.

CANCER TREATMENT FOR THE ELDERLY

NCI clinical studies continue to acquire knowledge about chemotherapy treatments in the older cancer patient. A major question is whether the elderly have been treated too gently, on the assumption that they could not tolerate vigorous treatment. And, if vigorous treatment is given, what are the results? Treatment outcome is influenced by a number of factors, including not only the chemotherapy dose, but the natural course of each type of cancer; the biological, not chronological, age of the patient; the individual's immune mechanisms; and perhaps other existing medical problems.

Treatment outcome from combination chemotherapy in older and younger patients with advanced Hodgkin's disease was compared by Bruce Peterson and colleagues in the Cancer and Leukemia Group B (a collaborative group of institutions conducting clinical studies with grant support from the NCI). Even in older patients who received and tolerated vigorous drug doses, the duration of survival was much shorter than in younger patients. However, Hodgkin's disease is not a common type of cancer in the elderly, therefore the shorter survival results in this study do not necessarily indicate that the same would be true in other cancers. For example, data from a series of studies by Colin Begg, Paul Carbone, and associates in the Eastern Cooperative Oncology Group (another collaborative group supported by the NCI), with large numbers of patients who had a variety of cancers, indicated essentially no difference in results of chemotherapy for older or younger patients. (The elderly patients were those well enough to meet the entrance criteria for the studies.) Both age groups had the same survival rates, and toxic effects of the treatment were also similar, except that lowered blood counts (with greater risk of infection) were more frequent for the elderly receiving certain drugs.

In 1981, a working conference cosponsored by the NCI and the NIA examined the problems and needs unique to the older person with cancer. As a result of this conference, and with continued cooperation between the two Institutes, the NCI recently approved a new research initiative, "Patterns of Care for Elderly Cancer Patients: Implications for Cancer Control" The NCI will fund research on various treatments (surgery, radiotherapy, and chemotherapy) for older cancer patients as well as interventions such as diagnostic procedures and staging (the classification of the extent of disease).

SUPPORT SYSTEMS

In the area of health education, the NCI's Cancer Communications Network is supporting contracts for projects to meet older patients' needs. One project, at Howard University in Washington, D.C., "Seniors Team Up Against Cancer," is designed to increase the awareness among older people of practices that contribute to early detection and treatment of cancer. Another project, "Cancer Awareness for the Elderly," at the University of Miami, is identifying knowledge, attitudes, and behavior related to cancer in the elderly. This project will serve as an information base to plan community programs. "Cancer Program for Older Citizens" at the Fox Chase Cancer Center involves production of educational materials and programs specifically for older persons.

NATIONAL CENTER FOR HEALTH STATISTICS

GOALS AND OBJECTIVES

The National Center for Health Statistics collects, analyzes, and disseminates national health statistics on vital events and health activities, including health status, morbidity, health resources, and health costs. Although the Center does not operate collection or analytical programs devoted to aging *per se,* the Center does collect and analyze data on aging as part of its broader responsibility to produce statistics on the Nation's health.

The Center collects health data about the entire population, regardless of age, and disseminates it through public-use data tapes (where the age of each subject is available) and reports in the Vital and Health Statistics series (where the category "age 65 and over" is presented at the minimum). The goals of the Center's analytical efforts are varied, ranging from general description, to generating hypotheses for future study, to testing of specific hypotheses. In view of the Center's role as the government's principal general-purpose health statistics organization, the majority of its reports fall into the general description category atlhough some in-depth analyses are conducted. Most of the Center's collection and analysis activities include the elderly as one segment of the Nation's population. Analyses which focus solely on the elderly or on health problems most prevalent among the elderly (e.g., stroke, osteoporosis) are conducted on an ad hoc basis.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

Heart, blood vessel, and lung disorders are both more common and likely to be more severe in people over 65. In addition, these people may present special problems with respect to diagnosis and clinical management owing to the combination of disease and the usual effects of growing old.

The basic approach to primary prevention of cardiovascular and pulmonary diseases has been to identify in individuals, their environment, or their habits and modes of life those factors that increase vulnerability to these disorders. A number of these factors—for example, elevated blood lipids (fats), high blood pressure, cigarette smoking, elevated blood sugar, sedentary habits, and others—can be modified by the patient alone or with the help of a physician. But against perhaps the most potent risk factor of them all—advancing age—neither the individual nor the physician can do very much. Moreover, it would appear that, with modifiable risk factors, the earlier the intervention the more likely it is to be effective. The question arises: how late in life can such interventions be undertaken with still decent prospects of reducing the aged patient's risk? Should people in their seventies and eighties be much concerned about their cholesterol or triglyceride levels, and will putting them on diet or drug regimens to correct blood lipid abnormalities really have any significant impact on their health or longevity?

The National Heart, Lung, and Blood Institute (NHLBI) believes that risk reduction makes sense at any age. Risk-factor modification has played a major role in the striking reductions, achieved since the mid-1960's, in mortality from heart and vascular disorders—particularly with respect to coronary heart disease and stroke, the leading killers among people over 65. These mortality reductions have added several years to the life expectancy of the average American adult, and it appears that the benefits have accrued to all segments of the population, irrespective of sex, color, or age.

Consider high blood pressure, a major risk factor for heart attack and perhaps the single most potent risk factor for stroke. The contract-supported NHLBI hypertension detection and followup program (HDFP) demonstrated convicingly that adequate blood pressure control could bring about substantial reductions in cardiovascular-disease mortality among subjects with higher-than-normal blood pressure-including borderline to mild hypertension that all too often had been considered best managed with benign neglect. The benefits of adequate therapy were apparent whatever the subjects' age or initial blood pressure level, but particularly impressive was the 45 percent reduction in the incidence of stroke achieved among older HDFP subjects (aged 60 to 69 at entry and 65 to 74 when the study ended).

However, the HDFP did not address a problem that often arises in older subjects. Usually, diastolic and systolic blood pressures tend to rise and fall in tandem, with diastolic pressure (the lower of the two numbers recorded when blood pressure is measured) being the more closely watched value in determining whether treatment is indicated. But in many older subjects, diastolic pressure may remain in the normal range for years while systolic pressure gradually climbs to hypertensive levels. Systolic pressure is that occurring in the arteries during the heart's pumping stroke, and it may rise in older subjects because their arteries lose elasticity with age, especially if arteriosclerosis is also present—as it usually is. Should isolated hypertension be treated in elderly subjects? The findings of the grant-supported Framingham Heart Study suggest that it should, since elevated systolic pressure appears to be at least as potent a risk factor for stroke as is the more usual variety of hypertension. But unanswered questions remain concerning when and how the condition should be managed. These issues may be resolved by a study to be jointly supported by the NHLBI and the NIA called the Systolic Hyertension in the Elderly Program. Now in the planning phase, the study will involve five participating clinics and 500 subjects, who will be followed for 5 years.

Many older people suffer from heart or blood vessel disorders that might be corrected or ameliorated by surgery. Recent evidence indicates that, if the elderly patient's general health status is good, age alone need not be considered a contraindication to such operations.

NHLBI surgeons found that diseased or damaged heart valves could be replaced in patients over 65 with an operative death rate little higher than that attending such operations in younger patients and with comparable relief of symptoms and improvements in heart function. For valve replacement in older subjects, they prefer using valves from pigs (porcine xenograft valves) to conventional artificial valves (although the latter may be more durable) because the animal grafts to not require that the recipient be given anti-coagulants postoperatively.

NHLBI grantees William S. Knapp and coworkers at Emory University in Atlanta report that coronary bypass surgery can be performed with acceptable operative risk and good long-term results among patients over 70 with angina that does not respond adequately to drug treatment. Among 121 elderly patients in their study, the hospital death rate was 1.6 percent versus 1.1 percent in a much larger series of operations on younger subjects. The elderly patients did not have a higher incidence of complications during and after surgery, but survival after 36 months (95 percent) was the same in older and younger patients and the benefits of surgery were also comparable in both groups.

However, L. R. M. Del Guerico (New York Medical College, Valhalla, N.Y. and J. D. Cohn (St. Barnabas Hospital, Livingston, N.J.) emphasize the need for very careful preoperative evaluation of aged patients facing any kind of major surgery under general anesthesia.

With support from the NHLBI, they employed cardiac catheterization (insertion of a tube into the veins or arteries of the heart) to gain detailed information on cardiac and pulmonary function in 148 surgical candidates over 65. All had previously been cleared for surgery on the basis of preoperative examinations done by internists. However, the more detailed examinations done by the investigators indicated that 63.5 percent of the patients had mild to moderate cardiorespiratory impairments that justified special precautions: corrective measures before surgery and careful monitoring during and after the procedure. There were eight operative deaths among these patients, four of them attributable to failure to take those special precautions. Another 23 percent of the patients had cardiopulmonary impairments judged serious enough to warrant a recommendation that the proposed operations be cancelled or, where possible, that some lesser procedure be done instead, preferably under local anesthesia. When these recommendations were followed, there were no operative deaths; when they were ignored, there were no operative survivors.

The investigators conclude that painstaking preoperative evaluations can spare many older patients from operations posing excessive risk and can reduce the death rate among those who do undergo major surgery.

Most deaths and serious disabilities from chronic obstructive pulmonary diseases (COPD), such as emphysema, occur among individuals over 65. Many people with far-advanced disease may require supplementary oxygen, sometimes on a continuous basis. This usually tethers the patient to the source of oxygen, whether it be a bulky tank, liquid oxygen container, or oxygen-enrichment apparatus.

NHLBI grantee Henry J. Heimblich, of Xavier University in Cincinnati, Ohio, has developed an oxygen-delivery system that is light enough to give the patient unrestricted mobility while meeting oxygen requirements for periods of up to 12 hours. Rather than using masks or nasal tubes, the system delivers the oxygen through a thin tube inserted through a small hole made in the patient's throat, with the tip of the tube positioned well down in the windpipe. This system is so much more efficient that the patient's oxygen needs can be met with much lower flow rates. Enough oxygen for up to 12 hours can be provided by a tank weighing only about 6 pounds which the patient can carry about in a shoulder harness. In the 21 patients who have used the system, it has caused no significant problems, has more than halved oxygen requirements (at considerable saving to the recipients), and has permitted formerly housebound patients to resume a more normal lifestyle.

The patient with advanced COPD should take such precautions as are possible against acute respiratory infections, since these can precipitate acute respiratory failure when superimposed on already marginal lung function. However, the patient's prospects for surviving such a respiratory crisis may be better than had previously been supposed, according to the findings of a recent study among COPD patients. NHLBI grantee R. T. Martin of the Veterans Administration Hospital and the University of Washington, Seattle, followed 36 COPD patients in whom an episode of acute bronchitis had precipitated acute respiratory failure. All survived, and only one required mechanical respiratory assistance. The remainder were managed successfully with conservative medical therapy.

The COPD patient should also avoid living at higher altitudes, according to the results of a recent NHLBI-funded study by L. G. Moore and coworkers, of the University of Colorado in Boulder. Death from emphysema in Colorado is higher than in the Nation as a whole, although Colorado's population is somewhat younger than the national average. In a study correlating death from COPD with altitude of residence within the state, the investigators found that deaths from emphysema occur earlier among residents living at altitudes of 7,500 feet or greater than among those residing at lower altitudes and after a shorter duration of illness. Whereas COPD patients living at lower altitudes succumb more often to pneumonia, those at higher altitudes die more often from cardiac complications of the disease, mainly right-heart failure. The investigators feel that thinner air at high altitudes further taxes diseased lungs that may already be straining to meet the body's oxygen needs. Inadequate blood oxygen (hypoxia) may then contribute to the development of pulmonary hypertension and ultimately to right-heart failure.

NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES

The National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDK) conducts and supports many projects directly and indirectly related to aging. A number of basic investigations examine metabolic processes which continue through the lifespan.

Age-related changes in androgen (male sex hormone) metabolism in adult and elderly men with benign prostatic hyperplasia (BPH) are being examined. BPH is commonly seen in men over age 50, and causes varying degrees of bladder outlet obstruction. Although the causes are unknown, BPH is thought to involve alterations in hormonal balance associated with aging. Other BPH studies examine age-related changes in the testes and prostates of dogs, rats, hamsters, and men.

Osteoarthritis, or degenerative joint disease, and osteoporosis, both associated with old age, are also being studied by NIADDK-supported investigators.

According to the Arthritis Foundation, about 16 million Americans have osteoarthritis, the most common form of arthritis. Under age 45, the prevalence is greater in men; over age 45, it is equally prevalent in men and women. In osteoarthritis there is a breakdown of the cartilage that cushions the joints, followed by bone overgrowth at joint margins. Symptoms of osteoarthritis tend to become worse in women after menopause, when estrogen levels decline. This finding suggests that sex hormones may influence cartilage metabolism and the development of osteoarthritis.

Several theories about the cause of osteoarthritis have been proposed but as yet there is not a definitive understanding of why and how the disease develops. However, a crucial problem seems to be that cartilage, when damaged for whatever reason, does not repair itself well. NIADDK-supported grantees, including Klaus Kuettner of Rush-Presbyterian-St. Luke's Hospital in Chicago, Henry Mankin at Massachusetts General Hospital in Boston, and Melvin Glimcher at Children's Hospital Medical Center in Boston, are studying the biochemistry, metabolism, and structure of the components of cartilage.

In a related area, research in replacements for joints damaged by arthritis or other conditions has progressed rapidly in recent years. Some 75,000 total hip replacements are performed on 65,000 patients each year, according to an NIH Consensus Development Panel, convened by the NIADDK in 1982 to evaluate this new form of reconstructive surgery.

According to the panel, "There is no question about * * * the overwhelming benefits" of this procedure, in terms of relief of pain and improved function. Some 90 percent of hip implants are functional ten years after surgery.

Osteoporosis, a progressive loss and weakening of bone, is a major medical condition affecting millions of postmenopausal women. The disease is thought to have multiple causes and be influenced by many factors, including impaired calcium metabolism, vitamin D deficiency, decreased estrogen production after menopause, and lack of exercise. NIADDK grantee Harry K. Genant and colleagues at the University of California, San Francisco, define "normal" postmenopausal bone loss as 1.7 percent per year. However, longitudinal studies in osteoporotic patients have shown that cancellous bone loss during active stages of disease may be as high as 9 percent per year, and cortical bone loss may be 2-3 percent per year. (Cancellous bone forms the inner support structure; cortical bone is the outer shell.)

Uncontrolled studies using small sample populations have shown that calcium, estrogen, and fluoride supplements are effective in treating osteoporosis. A recent Mayo Clinic report shows the results of such treatments to be cumulative, suggesting that combination treatments are best.

In response to an NIADDK program initiative, two grantees (Lawrence B. Riggs at the Mayo Clinic in Rochester, Minn., and Michael Kleerekoper at the Henry Ford Hospital in Detroit, Mich.) are examining the use of fluoride and calcium in the treatment of osteoporosis. Fluoride helps to strengthen bones, as well as teeth, and osteoporosis is less common in areas where water is naturally fluoridated. Approximately 400 patients will be recruited to participate in the studies.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

Many of the disorders found in the aged population are a consequence of diseases of the nervous system. The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) supports vigorous research on Alzheimer's disease and other dementias which affect the elderly. The interrelationship of age with communicative disorders such as presbycusis and tinnitus is also studied, as are Parkinson's disease, stroke, and problems of equilibrium.

ALZHEIMER'S DISEASE

Examination of the riddle posed by Alzheimer's disease is a major goal of the NINCDS. Most NINCDS-supported research on this disorder focuses on structural abnormalities and biochemical changes in the brain.

In recent studies at the Johns Hopkins University in Baltimore, NINCDS grantees Donald Price and Joseph Coyle have found that in Alzheimer's patients there seems to be a specific degeneration in a part of the brain called the nucleus basalis. The nucleus basalis has large cells and many connecting pathways to the brain's cortex, where there is extensive formation neuritic plaques (degenerating pieces of nerve cells surrounding a core of fibrous material within the brain's cortex). Scientists are intrigued by the nucleus basalis because it produces acetylcholine, a vital transmitter of chemical communication between nerve cells that Alzheimer's patients manufacture in progressively decreasing amounts. Since this loss of acetylcholine is so detrimental in Alzheimer's patients, scientists hope to learn why the nucleus basalis loses its ability to produce the substance.

NINCDS grantee Robert Terry of the Albert Einstein College of Medicine in New York has found that nerve cells of Alzheimer's patients have decreased amounts of an enzyme needed to manufacture acetylcholine. Peter Davies, another Institute grantee at Einstein, is following this lead by using radioactive and chemical methods to pinpoint the location of this enzyme.

Pursuing a different line of research, Einstein's Herman Buschke is conducting a longitudinal study of 500 nursing home residents who have been admitted to these institutions for many different reasons. Bushke's study, combining psychological evaluations of the residents with postmortem analyses of their brains, may lead to the development of psychological tests to improve the diagnosis of Alzheimer's disease.

The NINCDS positron emission tomography (PET) program is flourishing in centers across the United States and at NIH, permitting scientists to observe metabolic activity of the brain. PET's technique is already leading to new information about the structure and function of the brain. In NINCDS-supported work at the University of Pennslyvania in Philadephia, Martin Reivich and colleagues are exploring local cerebral glucose metabolism and how it is altered in various physiological and pathological situations.

PARKINSON'S DISEASE

Parkinson's disease (PD) is a movement disorder affecting nearly half a million Americans over age 50. This crippling disease costs the Nation some $2.5 billion annually.

While the cause of PD remains elusive, scientists now know that the brain cells that produce dopamine, a chemical vital to movement, somehow cease working in PD patients. Commonly prescribed drugs which compensate for this deficiency have helped to control the tremor and rigidity characteristic of PD, but the beneficial effect of these medications decreases with time. Disabling side effects are frequent, and often so severe that medication must be discontinued.

Several NINCDS-funded investigators are seeking to improve the pharmacological approach to the control of PD. Menek Goldstein and collaborators at New York University, for example, have found bromocriptine to be effective in PD patients, and the drug has now been approved by the Food and Drug Administration for wide use throughout the United States. NINCDS research has also shown the drug lisuride to be of benefit to PD patients.

COMMUNICATIVE DISORDERS

Among the chief goals of the NINCDS communicative disorders program is determination of the effects of aging on ways in which humans communicate with each other (speech, language, and hearing) or with their environment (balance, taste, and smell).

NINCDS grantees are improving diagnostic procedures to identify presbycusis (hearing impairment due to aging) and to differentiate it from other impairments, such as those resulting from noise exposure and drugs. Other studies are aimed at improved treatment and management of hearing loss in the aged, and better understanding of the aging process in the auditory system.

STROKE

NINCDS research programs emphasize studies on a national health problem affecting the elderly—cerebrovascular disease (stroke). Stroke is the Nation's leading neurological disorder and ranks third among all causes of death, as well as being among the major causes of long-term disability. A comprehensive attack on stroke is being carried out by NINCDS grantees in the U.S. and some foreign countries.

Three regional comprehensive stroke centers established by the NINCDS stroke research program serve as focal points for basic and clinical research, for the evaluation of local resources for patient care, and for technology transfer to speed delivery of research results to communities.

NINCDS grantee Fred Plum and his colleagues at the Cornell University center in New York City have conducted studies in primates which show that damage to the blood-brain barrier is of critical importance in the accumulation of fluid following cerebral ischemia. Ischemia occurs when a blood vessel is obstructed. Coagulation studies at the Cornell center have shown the usefulness of several compounds against blockage by blood clots of the arteries supplying the brain.

NINCDS-funded scientists working with Myron Ginsberg at the University of Miami center are studying the mechanisms of brain ischemia. They are now able to assess separately the mechanisms of injury in different portions of the affected brain. Other studies at the center are pursuing specific biochemical mechanisms which may speed up or slow down recovery after a stroke.

A 5-year international cooperative study on the value of a new surgical procedure for preventing impending stroke is nearing completion. The procedure, known as extracranial/intracranial (EC/IC) bypass, involves joining a scalp artery through an opening in the skull to the middle cerebral artery of the brain to supplement the brain's blood supply. A high surgical success rate has revealed that the operation is feasible, and of potentially great value to many older Americans.

Neurological disorders among the elderly pose special challenges, but the many scientists at work on these problems make the hope for solutions a realistic one.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

The National Institute of Allergy and Infectious Diseases (NIAID) conducts and supports research contributing to a better understanding of the causes of allergic, immunological, and infectious diseases and to the developent of better means of preventing, diagnosing, and treating illness. The Institute is concerned with several diseases and processes that have considerable impact on the older (45–65 years) and elderly (over 65 years) populations. Significant portions of its research programs can be classified as directed at these problems of aging.

The NIAID supports studies designed to determine how the immune system changes as it ages. Scientists have known that the body's immune system weakens with age. They have also known for about a decade that a hormone called interleukin 2 is an important ingredient of the body's immune response to infections. What they did not know was the relationship between the hormone and the aging process.

Working with laboratory mice, NIAID grantees William Weigle and Marilyn L. Thoman of the Scripps Clinic and Research Foundation in La Jolla, Calif., found that aged animals had at least 95 percent less interleukin 2 than their younger counterparts. The Scripps team recently reported that it was able to reactivate the immune system in aged animal cells simply by adding interleukin 2 to the tissue culture. While clinical use of interleukin 2 could be several years away, the investigators foresee the possibility of the hormone being used in conjunction with other drugs to help treat elderly patients battling infections and cancer. Weigle believes that the hormone probably would work best against ailments the body has never encountered before, such as new strains of influenza or tumor cells that represent new and formidable opponents to an aging immune system.

There are certain infectious diseases that have either a greater incidence or a more serious impact on the elderly than on other groups; influenza and pneumococcal pneumonia are examples.

Control of influenza infections in the elderly has depended primarily on vaccination. NIAID-supported scientists, headed by Raphael Dolin at the University of Vermont in Burlington, recently completed a clinical trial of two antiviral drugs ad preventives against influenza A. They enlisted 450 healthy volunteers from 18 to 45 years of age in the trial. Both drugs—amantadine and rimantadine—were effective in preventing influenza-like illness; however, more recipients of amantadine withdrew from the study because of side effects, mainly insomnia, jitteriness, and difficulty in concentrating. These side effects disappeared within 48 hours after the medication was discontinued.

On the basis of this study, the investigators concluded that rimantadine appears to be the drug of choice in the prophylaxis (prevention) of influenza A. They recommended that further studies be done to determine whether results, including the low rate of side effects, would be similar in elderly or other high-rish persons. Additional studies are also being considered to determine the utility of both of these antiviral compounds for the therapy of influenza infections in the elderly.

David W. Bentley, an NIAID grantee at the University of Rochester in New York, recently completed a 3-year study of the licensed pneumococcal pneumonia vaccine in the institutionalized elderly. The current vaccine contains 14 of the 85 serotypes of the pneumococcal bacterium. His findings indicate that vaccine-associated reactions were infrequent and not severe enough to prevent widespread use of the vaccine in this high-risk population.

Bentley estimates that vaccine efficacy 1 year after vaccination was approximately 35 percent in reducing the rate of vaccine-type pneumococcal pneumonia. Recently, the Food and Drug Administration's Bureau of Biologics and the manufacturers of pneumococcal vaccine have begun studies on a "second generation" vaccine that contains eight additional serotypes, including several of the predominant "nonvaccine" serotypes causing illness in Bentley's study population.

Results of this pilot study on the immune response of the elderly to the pneumococcus organism suggest that the serum antibody levels of the elderly do not remain elevated for as long, or in as high titers, as they do in young healthy adults. If these findings can be verified in larger groups of institutionalized and community-residing older persons, then the elderly might require revaccination with pneumococcal vaccine more frequently than the currently recommended intervals of at least 5 years.

Hospital-associated infections are a major medical problem for all age groups but take a more serious toll on the elderly, who often remain in hospitals and other institutions for greater periods of time than younger people.

A recent study of hospital-associated infections in surgical patients by Richard A. Garibaldi, and NIAID grantee at the University of Utah in Salt Lake City, revealed that these patients frequently receive prophylactic antibiotics for inappropriate indications or unnecessarily long durations. Patients with more severe underlying diseases were more likely to receive preventive medications improperly than were less compromised patients. This misuse of antibiotics contributes to the increasing costs of medical care. In addition, misused prophylactic antibiotics appear to predispose patients to antibiotic-resistant infections.

Garibaldi also conducted surveys in seven Salt Lake City nursing homes to determine the prevalence of infections among residents and to evaluate their infection-control policies. This study demonstrated what more casual observers of nursing home care have long known intuitively: that preventable infectious disease is common, and infection control programs in nursing homes are not well developed. The common types of infection in these nursing homes were bedsores, conjunctivitis, urinary tract infections, and lower respiratory tract infections. Patients were at highest risk of infection during their first 6 months of institutionalization. Garibaldi stressed the need for similar data on nursing homes in other localities to ascertain the magnitude of the problem nationwide and to establish guidelines or requlations to reduce infections in nursing homes.

OFFICE OF INSPECTOR GENERAL

INTRODUCTION

The mission of the Inspector General (IG) is to prevent and detect fraud and abuse in the Department of Health and Human Services (HHS) programs and to promote economy and efficiency in its operations. It is the Inspector General's responsibility to report to the Secretary and to the Congress any deficiencies or problems related to HHS programs and to recommend corrective actions.

The HHS Inspector General's Office is the first statutorily enacted office of its kind. It was created by Public Law 94-505 enacted on October 15, 1976, and was the result of a congressional initiative, inspired at least in part by disclosures of fraud, abuse, or waste in Federal/State medical and welfare programs. The legislation places equal emphasis on the Inspector General's obligation to prevent or detect wrongdoing and his obligation to make recommendations for program improvements in HHS.

A basic philosophy of the Office of Inspector General (OIG) is to work in a coordinative and cooperative way with other departmental offices to accomplish its mission except when such a relationship would compromise OIG independence. Close working relationships have been established with the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and other major components of the Department in order to maximize resources devoted to common problems.

ORGANIZATION

The Inspector General's Office is organized as follows into three major divisions: Audit, Investigations, and Systems Integrity.

The OIG Office of Audit prepares or reviews more than 5,000 audits annually which cover all aspects of HHS operations.

The Office of Investigations, headed by an Assistant Inspector General, is responsible for reviewing and investigating all allegations of a potentially criminal nature which involve HHS programs or activities.

The Division of State Fraud Control's primary responsibility is to manage the State Medicaid Fraud Control Unit (SMFCU) program; to work with the States to improve the detection and elimination of fraud against HHS programs; and to emphasize the importance of developing and conducting an in-house audit/investigation training program in cooperation with other SMFCU's.

Both the Office of Audit and the Office of Investigations have regional and branch offices. Each has 10 regional offices and 51 and 18 branch offices respectively.

The Assistant Inspector General for Systems Integrity directs a small staff of senior analysts with specialized experiences covering the spectrum of HHS activities. This office also manages the Service Delivery Assessment (SDA) staff function for the Secretary.

ACTIVITIES

OIG presently has a number of current projects which have an impact on programs for the aged. The following are examples:

—*Project 90+.*—An OIG match of 24,000 retirement, survivors, and disability insurance (RSDI) beneficiaries (over age 90) in metropolitan Chicago against Illinois death tapes yielded 25 unreported deaths. Current efforts are aimed at such matching for beneficiaries in the whole State.

—*Project spectre.*—In attempting to derive a profile for potential unreported deaths based on medicare records, OIG found that HCFA computer files have death reports (from health providers) that SSA's computer system did not process to RSDI records. A match of HCFA's records of deceased medicare patients against SSA's RSDI master file found 8,518 active RSDI records and an estimated (based on sample projections) $25M in accumulated overpayments.

—*Project payment process.*—OIG will redevelop 109,000 RSDI benefit payment records from Treasury, including face-to-face interviews with a sample of beneficiaries in Los Angeles and Chicago to uncover any unreported deaths, as well as errors in award and payment processes.

—*Alternative check delivery methods.*—OIG agreed to conduct a review of Federal and State efforts under way to combat losses of beneficiary checks presently utilizing U.S. Postal Service mailing services to determine if other, more secure methods of delivery were available. The first assessment was conducted in Pennsylvania, and Cook County, Ill., where we examined electronic systems of delivering checks and authorizations to purchase food stamps to determine potential for savings and the applicability of these systems to other States. Following the initial State assessments, an update of other efforts under way at the Treasury Department and within HHS was also evaluated. In each case, it was shown that alternative check delivery methods were cost-effective.

—*Integration of Social Security Field Integrity and HCFA's Office of Program Validation staffs into the OIG.*—Under a Secretary-directed transfer, the Office of Inspector General has obtained additional staff resources to combat fraud and waste in the Department's medicare and other social security programs. Full and complete integration of staff will be completed early next year.

During the past 2 years the OIG Office of Audit has conducted an issued numerous audit reports on programs affecting the elderly. Of these reports, 28 directly related to title III of the Administration on Aging (AoA). Other reports issued affected the elderly through such programs as supplemental security income, RSDI, medicare, and medicaid. These audit reviews showed a consistent pattern of financial management deficiencies. For example, we found a number of instances where fund accountability was inadequate. Some of the State agencies could not fully and properly account for their program funds because of a failure to maintain a system which properly recorded and analyzed expenditure reports received from area agencies. In some instances, a final determination that funds for the aging program were used for aging program objectives was not always possible.

While the congregate meals program, title III-CI, generates substantial amounts of program income from contributions received from the elderly, our examinations of the program disclosed a serious lack of adequate internal controls in accounting for program income. Frequently cited were situations in which there were no separation of duties among employees for the receipt, handling, and deposit of cash; or, the presence of adequate documentation to support allowable expenditures of program income.

Relative to the deficiencies found by various audit reviews, however, there is a marked improvement in the financial management of AoA programs throughout the country.

Finally, the Inspector General has testified on several occasions before the Senate Special Committee on Aging on problems of fraud and abuse in programs for the elderly.

Specific activities initiated during fiscal year 1982:

—Durable medical equipment (pacemakers). In fiscal year 1982 there were 102 management implication reports which identified program weaknesses conducive to fraud and abuse. These reports resulted in recommendations for systemic changes to reduce fraud and abuse. One such report on pacemakers resulted in recommendations to reduce costs to medicare by $64M.

—A new program of developing training and investigative guides for the more complex health provider investigations was instituted. The first three guides (on nursing homes, pharmacy, and dental frauds) were distributed to State and Federal investigators and auditors.

—Issuance of a memorandum of understanding with the Justice Department to permit aggressive pursuit of recoveries from fraudulent health providers using a newly enacted civil monetary penalties law. Manuals have been published and intensive traning sessions conducted on the legal and investigatory implications of the law. In addition, a system to track administrative sanctions throughout the department has been established.

—Increased use of computer applications to surface cases of fraud and abuse. In one project, a match of deceased medicare patients against social security beneficiary records resulted in recovery of about $8M in uncashed checks and remittances. Beneficiary payments avoided as a result of this process amounted to $25M this year alone. Also, as of July 31, 1982, approximately 300 cases are under consideration by US. attorneys for trial, and 11 convictions and 9 additional indictments have been obtained. Even more importantly, corrective action is being taken to prevent reoccurrence of this problem.

OFFICE OF THE GENERAL COUNSEL

Schweiker v. *Hogan*, 102 S. Ct. 2597 (1982)

In this decision a unanimous U.S. Supreme Court reversed a decision of the district court and upheld the constitutionality of §1903(f) of the Social Security Act. That provision sets an upper limit on the income eligibility standard which States may establish if they elect to have a "medically needy" program as part of their medicaid programs. The statute provides that this standard may not exceed 133⅓ percent of the AFDC payment standard. Justice Stevens, writing for the Court, rejected plaintiffs' contention that Congress did not intend to set this limit at a level which would result in medically needy individuals having less income (after subtracting medical expenses) than would an individual who qualifies for cash welfare payments (who is automatically entitled to medicaid). The Court found that the language of the statute clearly compels the result which plaintiffs challenged and does not conflict with any other provision of the act or the act's legislative history. Moreover, the Court held that the consistent interpretation of the provision by the Secretary of Health and Human Services provides further support for rejecting plaintiffs' interpretation of the provision (which necessarily departs from the literal language of the statute).

Finally, the Court held that the 133⅓ percent limit was not an unconstitutional violation of the equal protection component of the fifth amendment. The Court noted that the optional status of the "medically needy" program had already been held to be constitutional and plaintiffs did not challenge this result. Consequently, the Court reasoned that since the medically needy program is itself optional, plaintiffs' complaint of unfair treatment by comparison with the mandatorily covered categorically needy could be remedied simply if States eliminated their optional coverage altogether. Accordingly, the Court found that States may narrow the gap between the two groups (the mandatorily covered catergorically needy and the optionally covered medically needy) even if the result is that some of the medically needy are placed at a disadvantage relative to the categorically needy. The Court recognized that the plaintiffs had a powerful equitable argument in support of their claim of unfair treatment, but decided that the belief that an act of Congress may be inequitable or undair is not a sufficient basis for holding the act to be unconstitutional. The Court also found that it is rational to define "need" on the basis of gross income and therefore held that Congress need not define "need" based upon income after subtracting medical expenses.

State of Minnesota v. *Schweiker* (D. Minn. 1982)

In this decision the district court reversed the Department's determination and held that certain long-term care facilities in Minnesota were not institutions for mental diseases (IMD's). The medicaid statute prohibits Federal reimbursement for services to individuals over 21 and under 65 who are patients in IMD's. 42 U.S.C. §1396d(a). The court upheld the Department's position that the term IMD encompasses institutions other than large, traditional, State mental hospitals, such as skilled nursing facilities and intermediate care facilities. In ruling for the State of Minnesota, however, the court determined that the three institutions in question were not IMD's because they did not provide psychiatric treatment for their residents on the premises. The Department appealed the decision to the U.S. Court of Appeals for the Eight Circuit where the appeal is still pending.

Erika, Inc. v. *United States,* 102 S. Ct. 1650 (1982)

In this case the Court of Claims had held that it had jurisdiction to review claims for benefits under medicare part B (supplementary medical insurance, including physicians' services.) Under the Tucker Act, 28 U.S.C. 1491, notwithstanding the failure of the medicare statute to provide for this review and the express preclusion of jurisdiction under the Medicare Act, 42 U.S.C. 405(h). The district courts have generally refused jurisdiction over part B claims, either dismissing suits brought by part B beneficiaries, physicians, or transferring them to the Court of Claims. The Supreme Court, in a unanimous opinion, reversed the Court of Claims, and held that the medicare statute did not provide for judicial review of these claims, and that judicial review was therefore foreclosed.

Gray Panthers Update

On remand, the district court held that due process requires carriers to afford all part B beneficiaries with disputed claims amounting to $100 or less with an opportunity for an informal face-to-face oral hearing if their claims are denied after the initial determination and subsequent review by the carrier. The district court ordered that this relief be made available prospectively, and that such relief be provided retroactively and on a nationwide basis, to all beneficiaries who sought review of claims amounting to less than $100 from March 1976 through the present. In addition, the district court ordered the Secretary to replace the computerized notice form (EOMB) now utilized by carriers to inform claimants of the initial payment or denial of some 160 million part B claims annually with a new form proposed by the Gray Panthers. The Secretary has appealed all aspects of the district court's judgment.

On October 14, 1982, the court of appeals granted a stay of the district court's judgment insofar as it requires oral hearings during the pendency of the appeal. By order of November 4, 1982, the Chief Justice of the Supreme Court stayed the remainder of the district court's judgment. Inlight of the full stay of the district court's order, the Secretary has voluntarily initiated steps to implement an improved and more comprehensive explanation of medicare benefits form which, unlike that proposed by the Gray Panthers, will continue to be fully automated.

Schweiker v. *McClure,* S. Ct. 81-212

The Supreme Court unanimously reversed the district court decision, 503 F. Supp. 409 (N.D. Cal. 1980), which declared unconstitutional the use of carrier hearing officers to make final part B (supplemental medical insurance) hearing decisions. The Supreme Court held that factual findings disclosed no disqualifying interest of hearing officers to rebut a presumption that these officers are unbiased; and there was no basis in the record to show that carriers themselves are biased since carriers pay part B claims from Federal, and not their own funds, and the carriers operate under contracts requiring compliance with standards prescribed by the statute and the Secretary. The record also did not support the contention that accuracy of part B decisionmaking may suffer because the carriers appoint unqualified hearing officers, and that therefore additional procedures would reduce the risk of erroneous decisions. On October 20, 1982, the district court entered final judgment for the Secretary.

SOCIAL SECURITY ADMINISTRATION

Mathews, et al. v. *Schweiker* (N.D. Ala., 1982)

In this case, the district court held that the exception clause and the severability clause applicable to the pension offset provisions enacted as part of the Social Security Amendments of 1977 (Public Law 95-216) are constitutionally invalid. Under the pension offset provisions, a person receiving social security benefits as the spouse of a worker, will have his or her social security benefit reduced by the amount of any pension the person receives from a Federal, State, or local government agency for employment that was not covered by social security. The plaintiffs challenged the statutory exception to this provision which provides that this reduction will not occur if the person was either receiving or was eligible to receive a government pension for 1 or more months between December 1977 and November 1982, and met the conditions of entitlement for social security benefits as they were in effect and being administered in January 1977. In January 1977, persons claiming husband's or widower's benefits, but not wife's or widow's benefits, were required to show that they received one-half of their support from the worker. This one-half support requirement was later struck down by the Supreme Court as unconstitutional in *Califano* v. *Goldfarb,* 430 U.S. 199 (1977), and *Califano* v. *Abbott,* 430 U.S. 924 (1977). The district court in *Mathews* used these cases to find the exception and the severability clause invalid. Under the severability clause, if any part of the exception clause is held invalid, the entire exception clause becomes invalid and the offset becomes applicable to all individuals to whom it would otherwise apply. Notwithstanding the severability clause, the court ordered that benefits be paid to the plaintiff and the members of the nationwide class he represents. The Solicitor General has authorized direct appeal of the *Mathews* decision to the U.S. Supreme Court. The district court stayed its decision pending review of this issue by the Supreme Court.

Edwards, et al. v. *Schweiker* (9th Cir. 1982)

In this case, the District Court for the Northern District of California held unconstitutional section 211(a)(5)(A) of the Social Security Act, which governed the manner in which self-employment income derived from the operation of a trade or business by a husband and wife in a community property State would be credited for purposes of social security coverage. Under this provision, all of the gross income and deductions attributable to the trade or business were credited to the husband, unless the wife exercised substantially all of the management and control of the business, in which case all of the gross income and deductions were credited to the wife. The district court also ordered the Secretary to revise the earnings records of persons who operated a trade or business in community property States back to the beginning of the social security program. The Government did not contest the issue of the constitutionality of section 211(a)(5)(A) in the district court, but did oppose the relief sought by the plaintiffs. Thereafter, the Government sought appeal of the manner in which the district court ordered the Secretary to effectuate the court's decision. The ninth circuit dismissed the appeal filed by the Secretary on jurisdictional grounds, holding that the appeal of the district court decison should have been directly to the Supreme Court, rather than to the ninth circuit. To resolve the issues involving implementation and the jurisdictional question, the Solicitor General has filed a petition for certiorari requesting that the Supreme Court review the action of the ninth circuit dismissing the appeal.

Blankenship, et al. v. *Secretary of Health and Human Services* (W.D. Ky., 1982) and *Day, et al.* v. *Schweiker* (2d Cir. 1982)

In *Blankenship* the district Court for the Western District of Kentucky directed that the Secretary publish nationwide regulations which would provide a maximum time within which hearing decisions and decisions of the Appeals Council must be issued on certain social security and supplemental security income claims. The district court also held that if a claimant in the Kentucky class did not receive an administrative decision within the prescribed time, interim benefits would be payable until the administrative decision is issued. The sixth circuit stayed the order of the district court and is currently considering an appeal of the order filed by the Government, on the basis that no judicially mandated time limit regulation is appropriate. In *Day,* the second circuit upheld a decision of the District Court for Vermont which imposed time limits on the issuance of reconsideration and hearing decisions on certain claims and required the payment of benefits on an interim basis whenever the judicially imposed time limits are not met. The Secretary has recommended that the *Day* decision be appealed to the Supreme Court. It is the position of the Secretary that the imposition of time limits is not a reasonable or workable way to improve an administrative review process which must accommodate the more than 6 million claims which are filed annually for benefits under programs administered by the Social Security Administration.

Buffington, et al. v. *Schweiker* (W.D. Wash., 1981) and *Yamasaki, et al.* v. *Schweiker* (9th Cir. 1982)

In *Califano* v. *Yamasaki,* 442 U.S. 682 (1979), the Supreme Court construed section 204 of the Social Security Act to mean that when an individual who has received an overpayment of benefits under title II of the act requests that recovery of the overpayment be waived, the Secretary must give the individual "an opportunity for a prerecoupment oral hearing." Under the procedures SSA intended to use following this decision of the Supreme Court, when an individual requested that recovery not be made, SSA would review the written information furnished by the overpaid individual in support of the waiver request. If after this review, recovery could not be waived, the individual would be advised of the reasons why his or her request could not be granted and asked if he or she desired to schedule a personal conference. The individual would also be advised that if the personal conference was requested, SSA would take no action to recover the overpayment until a determination following the personal conference was issued. These proposed procedures are challenged in *Buffington,* a nationwide class action brought in the Western District of Washington and by the plaintiffs in *Yamasaki,* a class action consisting of persons residing in the State of Hawaii. At issue in both cases is the part of the procedure proposed by SSA which required that the overpaid individual advise SSA if he or she desired to schedule a personal conference. The plaintiffs in both cases sought the automatic scheduling of personal conferences. Presented with this issue in *Yamasaki,* the ninth circuit reasoned that the Supreme Court "did not refer to an opportunity to request a hearing," and that a reading of the Court's decision "leads inescapably to the conclusion that a hearing is required before commencing recoupment against a recipient who seeks waiver." The ninth circuit rejected, without an extended explanation, the arguments of the Secretary which discussed the reasonableness of the proposed procedures and the high costs of automatically scheduled personal conferences. The district court in *Buffington* has held that a personal conference must automatically be scheduled but has not yet issued a final order.

Ellender, et al. v. *Schweiker* (S.D. N.Y., 1982) and *Phillips, et al.* v. *Schweiker* (D. Mass., 1982)

These cases challenge certain initiatives taken by the Social Security Administration (SSA) to recover longstanding overpayments of supplemental security income (SSI) benefits payable under title XVI of the Social Security Act from overpaid individuals who are currently receiving social security benefits under title II of the act. Under regulations promulgated by the Secretary, an individual who has received an overpayment of SSI benefits and who is entitled to social security benefits may ask that the title II social security benefits be reduced until the SSI overpayment has been repaid. See, 20 C.F.R. 416.570 (1982). Earlier this year, notices were sent to overpaid individuals informing them again of their outstanding SSI overpayments and requesting either immediate refund or a voluntary adjustment of their title II benefits. The plaintiffs in *Ellender* and *Phillips* challenge both the notices and the proposed recovery of the debt by means of a reduction in title II benefits. The plaintiffs allege that recovery by adjustment of their title II benefits is precluded by section 207 of the Social Security Act which states that benefit payments are not assignable and not subject to attachment or other legal process. In an opinion issued in *Ellender,* the district court stated that it will grant the plaintiffs' motions for a statewide (New York) class and a preliminary injunction which temporarily would preclude recovery from the class of an SSI debt by a voluntery adjustment of title II benefits. It has not yet issued a final order. In *Phillips,* the district court first issued a preliminary injunction holding that SSA may not recover SSI overpayments from title II beneficiaries in Massachusetts who requested an adjustment in their benefits until the notices sent by SSA requesting repayment of the debt were revised to its satisfaction. Based upon new notices approved by the court, the court has now vacated its preliminary injunction which prohibited "cross-program recovery" in Massachusetts.

Tierney, et al. v. *Schweiker* (D.C. Cir. 1982)

In this case, the district court in Washington, D.C., and the Court of Appeals for the District of Columbia Circuit denied the plaintiffs' motion for an injunction pending an appeal of the district court's prior order which upheld procedures the Social Security Administration (SSA) has adopted for obtaining nonwage tax return information from the Internal Revenue Service regarding individuals who are recipients of supplemental security income (SSI) benefits. Earlier this year, under these procedures, SSA sent notices to approximately 4.6 million SSI recipients asking that they consent to SSA's receipt of tax return information sent to IRS by third parties. The information will be used to determine whether the recipients have received income or have resources which they have not reported correctly to SSA. The district court determined that the constitutional and stautory challenges raised by the plaintiffs are without merit. The plaintiffs' appeal is pending before the District of Columbia Cirtuit.

Soberal-Perez, et al. v. *Schweiker* (E.D. N.Y., 1982)

In this case, the district court dismissed an action brought to challenge the sufficiency of notices provided to Spanish-speaking individuals by the Social Security Administration (SSA) and the alleged inadequate number of Spanish-speaking personnel used by SSA. The plaintiffs contended that the policies of SSA denied Spanish-speaking claimants and beneficiaries equal access to the benefit programs. The district court found that there was no intent to discriminate against the plaintiffs by the Federal Government and that none of their fundamental rights had been violated. The district court also held that a rational basis exists for the use of English in the conduct of governmental affairs.

Powderly, et al. v. *Schweiker, et al.* (E.D. Wash., 1981) and *Dockstader, et al.* v. *Harris, et al.* (D. Utah, 1981)

These cases challenge the procedures used by the Department of Treasury and the Social Security Administration (SSA) to recover social security benefit payments erroneously made after the death of a beneficiary either by check or by direct deposit to a joint bank account and improperly converted by the surviving spouse of the deceased beneficiary. The plaintiffs contend that these erroneous payments are overpayments under section 204 of the Social Security Act and as such they may not be recovered until notice and a prerecoupment hearing is provided by SSA. Plaintiffs additionally allege that recovery of these erroneous payments should be be subject to the same waiver provisions applicable when a beneficiary receives an overpayment of benefits. The district court upheld the procedures and distinguished between erroneous payments made to deceased individuals and overpayments made to beneficiaries. The plaintiffs in *Powderly* have appealed the decision to the ninth circuit and the plaintiffs in *Dockstader* have appealed the decision to the 10th circuit.

Kron, et al. v. *Schweiker* (E.D. La., 1982)

The district court in this case held invalid § 3412 of the Medicare State Operations Manual, which defines a skilled nursing facility under § 1861(j)(1) of the Social Security Act for purposes of determining when a beneficiary's "spell of illness" ends under § 1861(a) of the act.

The court further enjoined the Secretary from implementing the definitional criteria set forth in § 3412 until he publishes those criteria in the Federal Register, as required by the Administrative Procedure Act, 5 U.S.C. § 552(a)(1)(D). The court disposed of the case solely on this basis and declined to rule on the issue whether the manual criteria also violated § 1861(j)(1) of the Social Security Act.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JANUARY 3, 1983.

DEAR MR. CHAIRMAN: Per your request of November 9, 1982, I have enclosed a copy of the U.S. Department of Housing and Urban Development's 1982 annual report to the U.S. Senate Special Committee on Aging.

Very sincerely yours,

SAMUEL R. PIERCE, Jr., *Secretary.*

Enclosure.

1982 ANNUAL REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING

INTRODUCTION

The Department of Housing and Urban Development's efforts to serve the elderly are characterized by concern to maintain and focus housing and services while achieving necessary budget savings. Under the leadership of Secretary Pierce, HUD has acted to assert administrative responsiveness and direction, to insure housing production, to provide opportunities for necessary auxiliary services, to protect the elderly it serves, and to pursue extensive research aimed at improving the quality of life of aging Americans.

This report to the Special Committee on Aging of the U.S. Senate is organized to show the pattern of HUD service, and the sections of the report are ordered to give a comprehensive view of HUD policy and programs. Coordination of services for the aging has been given administrative priority by being located in the Office of the Secretary, under the direct supervision of the Deputy Under Secretary for Intergovernmental Relations. Programs of direct loans and loan guarantees to provide adequate production of housing for the elderly are being maintained, and various offices of HUD are exploring methods of protection and service to the elderly we house. HUD has encouraged use of community development funds to complement HUD services through State and local discretion. This report describes some of the ways this is being accomplished. Finally, there is a presentation of current and projected research aimed at identifying useful ways of improving housing and services for the elderly.

The Department of Housing and Urban Development has entered the current period of Federal fiscal restraint confident that programs for the elderly will provide the flexibility and level of support necessary to meet the housing needs of the elderly in the 1980's.

I. INTERGOVERNMENTAL RELATIONS

In March 1981, Secretary Pierce established the Office of the Deputy Under Secretary for Intergovernmental Relations as a new office within the Office of the Secretary. This office serves as the focal point for secretarial dealings with the White House, with other Federal agencies, with State and local officials, and with public interest groups of intergovernmental policy matters. In May 1981, Secretary Pierce transferred the responsibility for policy recommendation and program coordination of functions relating to the elderly to the Office of the Deputy Under Secretary for Intergovernmental Relations. The position of Special Adviser for the Elderly was transferred to this office. This special adviser served as the staff director of the Housing Committee of the White House Conference on Aging and worked with staff directors of other Conference committees and with the executive director of the White House Conference on Aging to prepare the final report.

The responsibilities of the Office of the Deputy Under Secretary for Intergovernmental Relations as they apply to the elderly include maintaining contact with public interest groups representing the elderly and responding to their concerns about Department programs, working with the White House and HUD program offices to insure specific attention to the elderly population's concerns, and handling casework problems involving elderly populations. This office coordinated two significant Department meetings with leaders of organizations representing aging Americans. They were: a meeting with Secretary Pierce during Older Americans' Month to discuss aging issues and agency policy, and a meeting with Under Secretary Hovde to discuss the feasibility of adding an elderly component to the joint venture for affordable housing project. This office continues to work with organizations representing aging Americans, with Federal agency offices who work with the elderly, and with elderly individuals directly who have housing concerns.

II. HOUSING

A. Section 202—Direct Loans for Housing for the Elderly or Handicapped

The section 202 program was first enacted as a part of the Housing Act to 1959 to provide direct Federal long-term loans for the construction of housing for the elderly or handicapped. The program was intended to serve elderly persons whose income was above public housing levels but still insufficient to obtain adequate housing on the private market. The section 202 program was amended by the House and Community Development Act of 1974 to change the method of determining the interest rate (which had been set at 3 percent statutory maximum in 1965) and to permit the use of section 8 housing assistance payments for projects constructed or substantially rehabilitated under the program. In fiscal year 1982, the interest was 9¼ percent. In fiscal year 1983, the interest rate will remain at 9¼ percent.

Since reactivation of the program in 1974, nearly $3 billion has been reserved, representing 2,300 projects and 147,000 units. For fiscal year 1982, 326 projects with 15,633 units received fund reservations for $721.8 million. Approximately $453 million (estimated to finance the development of 10,000 units) will be available for fund reservation in fiscal year 1983.

B. Section 231—Mortgage Insurance for Elderly Housing

Section 231 of the National Housing Act, as amended, authorizes HUD to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons (age 62 years or older—whether married or single). Section 231 is HUD's principal program designed solely for unsubsidized rental housing for the elderly. Nonprofit as well as profit-motivated sponsors are eligible under the program and section 8 housing assistance payments can be made available on competitive basis. Section 231 permits congregate housing projects to be built. At the end of fiscal year 1982, the total number of projects insured under the section 231 program was 504. This provided 66,228 units for the elderly.

C. Section 221(d) (3) and (4) of the National Housing Act—Mortgage Insurance Programs for Multifamily Housing

While these programs are not specifically for the elderly, they are available to sponsors as alternatives to the section 231 program. Section 221(d) (3) and (4) authorize the Department to provide insurance to finance the construction or rehabilitation or rental or cooperative structures. Special projects for the elderly are provided under these programs. Since inception these programs have insured 9,880 projects containing 1,147,642 units. More than 10 percent of these units are for the elderly.

D. Section 223(f)—Mortgage Insurance for the Purpose of Refinancing Existing Multifamily Housing Projects

This program offers mortgage insurance for existing facilities, including housing for the elderly, where repair needs do not warrant substantial rehabilitation. The program can be used either in connection with the purchase of a project or for refinancing only. To the extent that real estate liquidity is enchanced, the availability of section 223(f) encourages investment in residential real estate of all kinds. Prior to its being added to the National Housing Act in August 1974, project mortgage insurance could be provided only for substantial rehabilitation or new constuction.

E. Section 232—Mortgage Insurance for Nursing Homes/Intermediate Care Facilities

The primary objective of the section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. The vast majority of the residents of nursing homes and intermediate care facilities are elderly. Since the program's enactment in 1959, the Department has insured 1,367 facilities, providing 162,062 beds, totaling $2 billion.

F. Section 8 Rental Assistance

Legislation requires that section 8 projects serve lower income and very low-income families. Further, some projects are developed with a mix of assisted families. In general, families assisted under section 8 pay 10 percent of gross income or

30 percent of adjusted income, whichever is higher, for rent. As of October 31, 1982, or the total of 1,873,827 living units added to the housing stock for section 8 certification, 782,774 (41.6 percent) were for elderly. It is expected that field offices will have only limited section 8 contract authority in fiscal year 1983, but this will be sufficient to cover section 202 projects.

G. Public Housing

Public housing was created by the United States Housing Act of 1937 and has always included the elderly as eligible residents. In 1956, public housing especially designed for the elderly, incorporating safety and security features, was authorized by the Congress. Handicapped persons of all ages with low incomes are statutorily included. Public housing agencies (PHA's) develop and operate the housing, financed through direct HUD loans and the sale of bonds and other obligations. The Federal Government assists with annual contributions to repay the PHA's borrowings and, with operating subsidies, assures that low rents and adequate services are available.

In 1970, legislation was enacted encouraging PHA's to develop congregate rental housing for the elderly and handicapped. Congregate housing differs from the usual multiunit housing in that the living units may not have individual kitchens, but must have a central kitchen and dining facility to serve communal meals. Supportive services may be provided by the PHA's, but most are provided by local social service agencies funded by the Older Americans Act and titles XIX and XX of the Social Security Act.

As of October 31, 1982, approximately 638,375 units of low-income public housing, or 42,9 percent, were occupied by the elderly. These figures do not include elderly occupying section 8 units owned by PHA's.

H. Indian Housing

The Department provides housing assistance for elderly Indians and Alaskan Natives pursuant to the U.S. Housing Act of 1937, as amended. The Indian housing program is similar to the public housing program. Indian housing authorities operate rental and homeownership programs on reservations. As of October 1, 1982, there were almost 170 Indian housing authorities operating approximately 46,100 units of Indian housing, of which approximately 3,000 units specifically house elderly families. Approximately 14,237 units are in the pipeline and will be available for occupancy within the next 3 years. Of these units in development, about 10 percent are for the elderly.

In collaboration with the State of Alaska, the Department has initiated an elderly demonstration project. The State of Alaska proposed, and HUD approved, a partnership to build a 120-unit low-income housing project for elderly Alaskan Natives in Anchorage (to be owned and operated by the Cook Inlet Housing Authority). The State of Alaska is contributing 75 percent of the development funds and HUD is contributing 75 percent of the development funds and HUD is contributing the remainder. Our Anchorage area office will have operational oversight for the project during its development. We view this demonstration as a means to meet joint responsibilities to house low-income Indian families which can be repeated in other States with the resources to enter into such partnerships. The Department will encourage tribes with substantial and availabale assets to contribute in the future to similar partnerships to increase the number to new Indian units.

I. Congregate Housing Services Program

The congregate housing services program is designed to test the cost-effectiveness of this type program for the elderly and handicapped. Under this program, HUD extends multiyear grants (3 to 5 years) to eligible public housing authorities and nonprofit section 202 borrowers for meals and other supportive services to frail elderly and nonelderly handicapped residents to help them remain independent.

As of 1982, all fiscal year 1979 money had been committed to grantees, except for $400,000 that is legislatively required to be held back to cover the cost of inflation and other adjustments. Thirty-three of these grants are serving approximately 1,600 residents.

Grants for four new construction projects will not be negotiated until initial occupancy in 1983. $10 million was available in fiscal year 1980 for grantees These grants were for 5 years and they now serve approximately 800 residents a year in 18 projects. $3 million of fiscal year 1980 funds reserved for new construction projects were allocated by competitive selection to eight grantees in July 1982. These grants are currently under contract negotiation.

J. Interstate Land Sales

Congress passed the Interstate Land Sales Full Disclosure Act in 1968 to give the public a measure of protection against fraudulent and deceptive land sales operations. The act is administered through HUD's Office of Interstate Land Sales Registration. Although the act is intended to provide protection for all consumers, it is evident that a greater number of potential victims of fraudulent land sales are the elderly.

The property report is the key to the protection available to consumers under the act. Developers are required by law to give the prospective purchaser a property report prior to or at the time of signing a contract. As provided for in recent statutory changes, the Department has conducted negotiations with several States concerning the certification of their land sales efforts as equivalent to protections provided by Federal law. Thus far, the States of California, Minnesota, Florida, and Arizona have been certified. This was effectively reduce the Federal presence in those States even though the act's antifraud and antimisrepresentation provisions still apply.

III. COMMUNITY PLANNING AND DEVELOPMENT

A. Community Development Block Grant Program

The community development block grant (CDBG) program is a major funding source for cities to conduct a wide range of community development activities. It makes available approximately $3.5 billion annually to communities, of which, approximately $2.5 billion goes to 650 cities and urban counties by entitlement—with the amounts determined by formula. The balance, approximately $1 billion, goes to small cities under 50,000 population. Beginning in fiscal year 1981, most of these funds were allocated directly to States for distribution according to the States' own selection systems. HUD area offices distributed the remainder through competition in their area of jurisdiction. Block grant funds must be expended to help low- and moderate-income households, to eliminate slums and blight or to meet urgent community development needs. The primary objective of the legislation is the development of viable urban communities by providing decent housing, a suitable living environment, with expanding economic opportunities, principally for persons of low and moderate income.

Elderly persons benefit directly and indirectly from a variety of CDBG funded projects. However, because of the decentralized nature of the CDBG program and because local communities are not required to report program beneficiaries by age, it is impossible to estimate exactly what proportion of CDBG funds directly addresses the needs and problems of the elderly. Nevertheless, information is available indicating that slightly more than 0.8 percent (approximately $16 million) of all fiscal year 1981 CDBG funds were budgeted specifically for senior centers. Metro cities planned to use 0.6 percent of their funds for this purpose, urban counties 2.2 percent, and small cities 0.6 percent. Another major source of elderly benefits in the CDBG program is local funding for housing rehabilitation activities. Housing rehabilitation funding represents approximately 38 percent of all CDBG spending. Although the exact proportion of the funding that benefits the elderly cannot be determined, it is generally believed to be significant. Some of the more popular CDBG home improvement projects intended for elderly persons have involved writing down the interest rates of conventional home improvement loans, deferring repayments of loans for the local government for a specified period of time, approving home improvement grants for elderly homeowners, and improving and weatherizing the homes of elderly citizens.

In addition, CDBG spending for neighborhood improvements, public services, and public works indirectly benefits the elderly. In 1981, CDBG entitlement cities and urban counties allocated about $9 million to centers for the handicapped, $60.7 million for neighborhood facilities, $28.5 million for public housing modernization, $15.4 million for the removal of architectural barriers, and $192.7 million for the provision of public and social services. Again, it is not possible to estimate the total CDBG benefits to the elderly. However, entitlement cities have directed about 57 percent of their funds (close to $1 billion) in each of the past 3 years to areas in which at least 10 percent of the population was 65 or more years of age.

A 1980 survey of accomplishments resulting from the CDBG program conducted by the Office of Program Analysis and Evaluation provides specific examples of the results of the CDBG spending that have benefited the elderly. Nationally, entitlement communities built or improved 705 senior centers from 1975 to 1980. These centers were located in a wide variety of localities. For example, communities of 1 million or more population reported an average of 5.3 senior centers built or improved. Communities of less than 100,000 population had the highest total, with 310 centers built or improved. Entitlement cities also reported that they provided CDBG-funded elderly services to almost 22 million individuals in the 5-year period from 1975-80. On average, each entitlement city provided elderly services to over 123,000 individuals per year, roughly three times the number provided by smaller communities and over 10 times the figure for urban counties.

In summary, the CDBG program is a multifaceted program which local communities continue to use to provide a broad range of useful and needed support for the elderly.

B. Section 312 Program

The section 312 rehabilitation loan program, as established by the Housing Act of 1964, provides direct loans to eligible property owners to assist them in rehabilitating single family and multifamily residential properties and neighborhood-scale nonresidential properties. The program has recently operated in conjunction with and in support of other community development programs, primarily the community development block grant (CDBG) and the urban homesteading programs.

Most section 312 loans in the past have gone toward single family loans. The 1981 amendments, however, removed restrictions on the amount and circumstances for multifamily lending. Rehabilitation loans are made at low interest rates (3, 6, or 9 percent) depending upon the family income for residential single family properties, or upon the type of property for other loans. The term of the loan is the shortest reasonable term consistent with the borrower's ability to pay, but in no instance is it more than 20 years.

In fiscal year 1981, 465 loans or 16 percent of section 312 rehabilitation loans were made to owner-occupants who were 62 years of age and older. This compares with 16.6 percent in the previous fiscal year.

In fiscal year 1982, the section 312 program was funded almost entirely for repayment proceeds from previously originated loans and recoveries of prior years' obligations. Congress authorized continuation of the program for fiscal year 1983, again directing that repayments and recoveries be used for any new section 312 loans.

C. Urban Development Action Grant Program

The urban development action grant (UDAG) program provides grants to cities and urban counties which meet minimum standards of physical economic distress. The purpose of the program is to improve the economic base of those cities and provide permanent jobs, especially for low- and moderate-income persons. The program seeks to attract private investment to distressed localities; no grants are approved unless there are firm commitments of private funds to carry out project development. Preliminary approvals of action grants are based upon nationwide competition on a series of factors including the relative distress of the city, how much private money is attracted by the UDAG grant, the number of jobs created, the seriousness of the economic problems of the locality, and other factors. In 1979, a "pockets of poverty" provision was added to the program, permitting localities which are not distressed to apply for grants to assist areas of the city which have many low-income households.

Since 1978, 71 projects in over one-half the States and Puerto Rico have been awarded funds which help to meet the needs of the elderly. Listed below are examples of projects approved during 1982 which directly benefit elderly persons and househholds:

Canton, Ohio.—To renovate and convert an old downtown high school building to include a 203-bed nursing home and medical offices.

Chattanooga, Tenn.—To construct 115 rental apartments of which 45 units will be for the elderly and/or handicapped.

Cleveland, Ohio.—To renovate and expand an existing nursing home from 89 to 218 beds.

Douglas, Mich.—To construct a 24-bed nursing home, 25 units of sheltered care apartments, and a medical clinic.

Marion, Ohio.—To construct a 100-bed nursing home.

New Orleans, La.—To construct an 89-bed intermediate care nursing facility.

Philadelphia, Pa.—To construct a minority-owned, 120-bed nursing home in North Philadelphia.

Scranton, Pa.—To construct a 120-bed nursing home and expand a rehabilitation care facility.

IV. LABOR RELATIONS

Labor costs are 25 percent of housing construction and 50 percent of public housing maintenance costs. These costs obviously affect housing for the elderly and the Davis-Bacon prevailing wage statute has a great cost impact on housing for the elderly.

The Office of Labor Relations has worked to improve the quality of life in public housing for the elderly. Numerous public housing authorities make it a practice to provide housing at little or no cost to janitorial staff in order to induce them to live on the premises. This practice holds down crime and increases responsiveness to maintenance emergencies. Research and analysis showed this to be a fairly widespread local sector initiative and to be much more cost effective than Federal subsidy programs. This office has worked to make sure that a live-in worker is protected from having his apartment treated as income for social security tax and other tax purposes.

Until the end of the fiscal year the Office of Labor Relations coordinated the youth anticrime program, a joint program using HUD, Department of Justice, and CETA funds. Since September 30, 1982, the Secretary has worked with local housing authorities on private sector initiatives to support anticrime programs. These programs address security concerns of the elderly in these projects.

V. POLICY DEVELOPMENT AND RESEARCH

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing, and demonstrations relating to the mission and programs of the Department. Section 815 of the Housing and Community Development Act of 1974 specifically encourages demonstrations related to the housing problems of the elderly and handicapped. The focus of this program related to the elderly and handicapped is to design, conduct, and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of special groups.

The Office of Policy Development and Research is currently sponsoring several projects related to the housing problems of the elderly. The elderly home maintenance demonstration, conducted in seven cities, entered its second year of operation. Enrollment targets of 125 clients per city were maintained, and reinspection and repair services delivered on target. Even though this demonstration ended in the summer of 1982, several sites were able to obtain funds from other sources for continued service delivery. An evaluation of the demonstration is currently underway. Results are expected to be available by spring of 1983.

During fiscal year 1982 the evaluation of the congregate housing services program (CHSP) continued. Data was collected that will be used to measure CHSP program impacts on rates of institutionalization, hospitalization, mortality, physical functioning, and health status, whether the services are substituting for privately (i.e., family, friends) provided supportive services, and whether the services were being targeted to the most needy. In 1982, additional data collection efforts were initiated and preliminary analyses of targeting and resident profiles were begun. The complete impact analysis and evaluation results will not be available until mid-1984.

HUD also has an ongoing research program to evaluate housing assistance activities. As part of this effort, HUD has completed two research studies, which provide information on the use of HUD subsidy programs to address housing needs of elderly persons. "Participation and Benefits in the Urban Section 8 Program" (January 1981) provides data on elderly participation in the section 8 new construction and existing housing programs. "The Costs of HUD Multifamily Housing Programs" (October 1982) describes the development costs and life-cycle subsidy costs associated with construction of HUD-assisted housing; this includes housing developed under the section 202 program for elderly and handicapped individuals, and housing for the elderly that was built under the section 8 and public housing programs.

Another focus of the research program is on the handicapped; much of that research has major implications for the elderly who face many of the problems that the handicapped face. In response to a congressional directive that the chronically mentally ill become active participants in HUD's elderly housing program (section 202 housing), a project began in 1982 to develop standards and criteria for the design and operation of housing for the chronically mentally ill. The project will take 9 months to complete.

VI. FAIR HOUSING AND EQUAL OPPORTUNITY

Congress passed the Age Discrimination Act of 1975 to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Department of Health and Human Services is the agency responsible for coordinating the governmentwide implementation of the Age Discrimination Act. HUD published its proposed age discrimination act regulation in the Federal Register on November 4, 1980. We project that the final regulation will be ready for publication before January 1983. HUD received five complaints alleging age discrimination in obtaining housing. All five complaints were referred to the Federal Mediation and Conciliation Service (FMCS). FMCS is the designated agency for handling age complaints.

ITEM 8. DEPARTMENT OF THE INTERIOR

JANUARY 6, 1983.

DEAR MR. CHAIRMAN: Secretary Watt has asked me to respond to your November 9, 1982, request concerning the 1982 annual report of the Senate Special Committee on Aging entitled "Development in Aging." We certainly appreciate the coverage you gave Interior in your 1981 annual report, and we are delighted to submit information for your current report.

Our bureaus and offices have responded on the developments in aging in their programs and services, and we are pleased to submit their reports (attachments A–M) consistent with guidance from your committee staff. The attached reports contain information on reemployment of disabled annuitants; nondiscrimination; equal employment opportunity efforts; meeting the needs of the elderly in the trust territories; the senior community service program and the senior volunteer program in land management; custodial care, social and housing services, law enforcement, and education for older American Indians; employment of 14 employees over age 80 (two born in 1896) and 280 employees over age 70 at GS–1 through GS–15 grade levels in the Department; 69 employees with 40-year service awards, 206 employees with 30-year awards, and 350 reemployed annuitants in the Geological Survey; use of technical expertise from experienced employees in the Bureau of Mines; recreation for the elderly by the Bureau of Reclamation, architectural accessibility and group tours on Fish and Wildlife refuges; and senior citizen programs, the "Golden Age Passport," volunteer senior citizens, recreation activities, and urban park and cooperative State programs by the National Park Service.

As our bureau and office reports indicate, we continue to be sensitive to, and supportive of, the needs and issues of gerontology. We look forward to working with your Special Committee, compliment the committee's efforts on behalf of the elderly, and will be pleased to provide additional information by contacting Dr. Andy Adams on my staff (343–5521) who assisted me in the preparation of this correspondence.

Sincerely,

RICHARD R. HITE,
Principal Deputy Assistant Secretary
for Policy, Budget and Administration.

Enclosures.

OFFICE OF POLICY, BUDGET AND ADMINISTRATION

In the Department we announce all positions, except firefighters and law enforcement positions, as open to all applicants regardless of age. As of September 30, 1982, there were 289 employees on the rolls who were 70 years old or over. There are 14 employees in their eighties; two of these employees were born in 1896. The 289 individuals are employed at all grade levels from GS–1 through GS–15. The type of appointments include career, career conditional, wage grade, wage board, foreign, and temporary.

Public Law 95–437, the Federal Employees Part-time Career Employment Act of 1978, provides career part-time employment opportunities in positions through GS–15 (or equivalent) subject to agency resources and mission requirements. This program is attractive to older persons with the skills, experience, and qualifications to reenter the job market on a part-time basis.

As a result of the decision in *Moysey* v. *Andrus*, the regulation on medical reexamination of annuitants who are age 60 and over has been revised. Under the revised regulations, any annuitant who is age 60 or over may now request medical reexamination to determine if he or she has recovered from the disabling condition on which his/her annuity is based.

In a disability retirement study conducted by the Office of Personnel Management (OPM), it was determined that OPM policy discouraged the reemployment of disability annuitants by limiting such employment to temporary appointments of less than 1 year. This policy resulted in many annuitants being retained on disability retirement longer than was necessary. The revised disability retirement regulations now permit a disability annuitant to be reemployed in any position for which he/she is qualified, with the kind of appointment otherwise appropriate under the circumstances. The reeemployed annuitant will have his/her pay offset by the amount of annuity allocable to the period of reemployment. A disability annuitant so employed may request to be found recovered at any time, and when the nature of the appointment is such that it would otherwise be subject to retirement deductions, OPM will terminate the annuity as of the date of its administrative finding of recovery and the agency shall commence retirement deductions as of the same date. These revised procedures will encourage reemployment among the employable disability annuitants while protecting the right to future benefits of those not fully recovered.

ACTING PERSONNEL OFFICER, OFFICE OF THE SECRETARY

This is in response to your November 17, 1982, memorandum which requested information about this Division's fiscal year 1982 activities in respect to the aging for inclusion in the Department's report to the Senate. We have reviewed our policies with respect to age discrimination and find them in conformance with section 3307 of title 5, U.S. Code. A review of the records show that older candidates for employment are receiving full and fair consideration and no maximum age limits are set for positions in the Office of the Secretary.

This Division has no specific programs or services directly involving the aging.

OFFICE OF THE SECRETARY, EQUAL OPPORTUNITY OFFICER

The Department of the Interior personnel actions are covered by the Age Discrimination in Employment Act of 1978 (Public Law 93-259), amending the Age Discrimination in Employment Act of 1967, the Civil Service Reform Act of 1978 (Public Law 95-454) and other statutes, court decisions, and Executive orders as well as various other regulations promulgated by either the Federal Government or the Department. Pursuant to such orders there were a series of actions in the Office of the Secretary and other departmental offices (OS/ODO) during 1982:

(1) For its February meeting of EEO cordinators and counselors, the OS Equal Opportunity Office sponsored a human relations film, "Perceptions and Reliefs," which highlighted common stereotypes of different groups including the aging.

(2) In May, a film, "Images of Aging" was sponsored by the Office of the Secretary Equal Opportunity Office for preview by EEO coordinators and counselors followed by a general discussion.

(3) The OS/ODO and solicitor's EEO policy statements which include age among protected classes were reissued.

(4) A chronology of selected actions of the executive, legislative, and judicial branches of Government from the 1700's to 1982 was prepared by the OS Equal Opportunity Office and disseminated throughout the Department. It includes action on age.

(5) "Trigger Words," a human relations pamphlet on proper transcultural communication was prepared by the OS Equal Opportunity Office and disseminated throughout the Office of the Secretary. Age is included as a factor in communication.

(6) The OS Equal Opportunity Office continued to process complaints of discrimination including counseling and precounseling, on the basis of age.

(7) Age was one of the considerations in the selection of EEO coordinators and counselors and EEO Advisory Council in the OS/ODO.

(8) The OS EEO Advisory Council included age discrimination as a prohibitive factor in its deliberations.

(9) Personnel/EEO UPDATE, a series of special seminars targeted to managers, supervisors, EEO coordinators, EEO counselors, and OS/ODO employees at-large included the subject of age in the various presentations.

(10) Monthly meetings with EEO coordinators and EEO counselors have included special forums on the need for sensitivity, responsiveness, program planning, and evaluation pursuant to age with handouts.

(11) Community relations activities included meetings, forums, lectures, and organizational activities to enhance outreach activities on the basis of age and other EEO-related subjects.

(12) In 1982, for the first time OS/ODO EEO awards were made for outstanding contributions. Responsiveness to age was among the criteria for the two who received such awards.

Financial Assistance Programs, Office for Equal Opportunity

We continue to await word from the Department of Health and Human Services (HHS) as to when we may publish in the Federal Register, Interior's final rule for enforcement of the Age Discrimination Act of 1975. The act prohibits discrimination on the basis of age in programs and activities receiving Federal financial assistance. As reported in last year's report, we were requested by HHS to not publish our final rule until they had resolved a dispute with the Office of Management and Budget (OMB) concerning a self-evaluation requirement. This request by HHS was made on June 4, 1980. To date, we still have not been informed as to the status of this dispute.

On November 18, 1982, a letter was sent to HHS requesting advice as to when we may be able to publish our final rule, to which we are awaiting a reply. Once this rule has been published, we will be able to actively enforce the provisions of the act among recipients of departmental financial assistance.

We have and are still making informational materials available to recipients which state the nondiscrimination policy of the Department that all financially assisted programs must be operated free of discrimination, including discrimination on the basis of age. These materials, a poster and brochure, have been widely disseminated and are still being requested in large numbers by recipients.

During fiscal year 1982, a complaint alleging discrimination on the basis of age was filed with this office. The complaint, alleging discrimination by a recipient of Interior financial assistance, was accepted for investigation. We are currently in the process of negotiating a settlement of the complaint with the recipient.

In our efforts to inform recipients of Interior financial assistance as to the requirements of civil rights legislation to which they must adhere, we encourage and accept invitations to provide technical assistance to recipients. In February of this year, we made a presentation at a meeting of representatives of State fish and game agencies in region 4. A portion of this meeting was devoted to a discussion of the Age Discrimination Act and its relation to recipient programs. We also provided a listing of special interest organizations, including those devoted to the interests of aging Americans. Recipients were encouraged to establish liaison with these organizations in an effort to inform them of their programs and to share issues of mutual concern.

We have devoted a significant amount of time to discussing with recipients ways in which to make their programs accessible to the handicapped. Recipients have been encouraged to utilize methods and equipment, such as ramps for the wheelchair bound, audio visual materials for the hearing impaired, and large print materials or readers for the vision impaired. Since a large percentage of the aging population of the country experience many of these disabilities, these types of modifications will succeed in making recipient programs more usable by and enjoyable for aging Americans.

We will continue our efforts to insure that aging Americans have an opportunity to participate freely in State and local programs that have received financial assistance from the Department. If we may be of further assistance, please let us know.

Office of Assistant Secretary, Territorial and International Affairs

THE TRUST TERRITORY OF THE PACIFIC ISLANDS (TTPI) 1982 REPORT ON DEVELOPMENTS IN AGING

As the termination of the U.N. trusteeship becomes reality, many program responsibilities are being transferred to the three new governments. The need for training of staff in each of the new governments remains an important issue. Consequently, a prime focus in 1982 is the continuation of 1981 program initiatives.

The TTPI is providing the following summary of its programs for the elderly during 1982. With funding from the U.S. Departments of the Interior and Health and Human Services, the Trust Territory Office on Aging (TTOOA), sponsored programs in each of the three governments within the TTPI: The Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia (FSM). In each of these governments, aging program coordinators and elderly advisory counsels have cooperated in assessing the needs of the elderly and delivering services. The interaction of traditional and elected leaders, aging program personnel, and the elderly themselves, resulted in the identification of the concerns of elderly and the development of programs which acknowledged those concerns through supporting existing services and supplying needed resources not currently available.

Employment opportunities were provided for a total of 263 elderly, most of whom worked as cultural teachers. Others contributed to their communities as cooks, carpenters, beautification workers, homemakers, and senior center recreation and program staff. A highlight of the employment program is the increasing focus on the skills of the elderly, evidenced by the overwhelming community support of activities such as the craft fairs in Palau at which the elderly program enrollees showcase their talents. To improve the health and general well-being of the elderly, nutrition programs were sponsored in each of the governments, with new services initiated in Kosrae (FSM), and Ebeye (Marshall Islands). Home-delivered meals were provided to 1,025 homebound elderly. Congregate meals were served in multipurpose senior centers to a total of more than 1,880 who were able to gather for food and fellowship. In the FSM, homes of 173 elderly were renovated in order to provide a safer, healthier, and more comfortable environment for frail elderly. To provide improved comfort, health, and independence of more than 2,182 disabled elderly, the geriatric home health program afforded homemaker assistance, rehabilitation therapy, family counseling, health education, and nursing/dental care or appropriate referrals. Transportation and legal services were given to 737 elderly. Information and referrals programs provided improved access to services for 293 elderly.

GUAM 1982 REPORT ON DEVELOPMENTS IN AGING

The 1982 activities for the elderly for Guam include the following:

(1) On September 3, 1981, at the conference of the Association of Pacific Basin Chief Executives, the governments of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and the Federated States of Micronesia, officially incorporated themselves under the name of the "Pacific American Territories on Aging Council" (PATAC). At that conference, a resolution was passed requesting endorsement, support, and commitment from these Pacific governments to PATAC's goals "to assist, formulate, and enhance the voice of the Pacific governments in policies relating to the aging and the aged."

(2) PATAC seeks policy changes on issues concerning health care, housing, and transportation:

(A) The proposed policy recommendations are "to modify Federal legislation and attendant regulations to improve health care delivery systems so that these systems are more relevant to meet specific needs of our elderly and clearly define the Older Americans Act and applicable regulations to include and support the comprehensive health systems often inadequate or absent in respective areas."

(B) With regard to housing, PATAC "requests that Federal policymakers be more sensitive to the traditional extended family system among Pacific Islanders, and that Island planners be given the option to formulate the best possible programs to meet the elderly's needs and to utilize and maintain the familial cultural ties."

(C) PATAC recommends that "special consideration must be given to develop alternative modes of transportation compatible with the Archipelago of these Pacific Islands."

(3) "PATAC recommends that the Administration on Aging within the U.S. Department of Health and Human Services draft and forward to the U.S. Congress proposed legislation that would amend the Older Americans Act to provide a special provision or introduce a new and separate title for the Pacific Island elderly."

(4) PATAC strongly supports the following solutions regarding funding: "(A) that authorization be granted for utilization of existing funding sources under the act (the Older Americans Act) to provide constructive program implementation for meaningful and relevant services responsive to Pacific Island needs, (B) that the Administration on Aging establish effective interagency agreements with other national agencies whereby unused funds committed to a program for the elderly in one agency that is not being implemented on the local level may be transferred to another agency which could better utilize existing funding, and (C) that the Pacific basin governments identified with PATAC be given priority on the reallotment of Federal funds under the Older Americans Act for use by other State offices on aging."

AMERICAN SAMOA 1982 REPORT ON DEVELOPMENTS IN AGING

During fiscal year 1982, American Samoa continued to implement fiscal year 1981 aging program initiatives which provided supplemental nutrition through cold and hot meals, transportation for those otherwise unable to absorb the cost involved, provided legal services, health aids, and renovation to homes occupied by elderly people. While the program has been multifaceted, it has been necessarily modest due to the limited resources available to American Samoa. Nevertheless, program accomplishments are considered essential to meet the minimal needs of the eligible people in American Samoa.

Demographic data continually indicates the elderly population in American Samoa is increasing at a rapid rate. Considerable stress is therefore placed on the limited fiscal and human resources, thereby making the critical issues in aging more difficult to address and more complex to resolve.

Economic security: The Territorial Administration on Aging has identified and operated under a primary objective of developing local, State, and Federal policy recommendations affecting the income of elderly Samoans. The diminishing amount of public funds available for financing programs for the elderly has created an urgency in developing equitable distribution methods. Inflation was recognized as the elderly's greatest barrier to attaining economic security, a barrier which is rapidly escalating and creating a situation where poor and middle-income older persons alike are experiencing increasingly greater difficulty in meeting essential needs.

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS 1982 REPORT ON DEVELOPMENTS IN AGING

I. Program Authority and History

The Commonwealth of the Northern Mariana Islands Government became eligible to apply direct funding to operate the various services and activities affecting the elderly as a result of the signing of the covenant to establish a Commonwealth of the Northern Mariana Islands in political union with the United States of America under section 703(a), relative to availability of Federal programs and services and that of the Older Americans Act of 1965, as amended and other Federal acts affecting the elderly. The following are the current acts and programs operating in the Commonwealth of the Northern Mariana Islands.

II. Older Americans Act of 1965, As Amended

The act provides assistance in the development of new or improved programs to help older persons in the areas of community planning and services, training, research, and development of programs.

Programs

(1) Title III-B, social services program.—This section of the act provide broad range of services and activities in the areas of transportation, outreach, and information and referral services. The following services are currently operating under this title:

(a) Transportation services.—Number of clients served: On as needed basis. Provide transportation services to and from the senior center, Monday thru Friday. Provide other transportation service in the areas of shopping, troubleshooting needs and problems upon request.

(b) Homemaker services.—Number of clients served: 150. Provides basic household chore services to the elderly.

(c) Information and referral services.—Number of clients served: 300. Provide information and referral to public and private agency that can best help and benefit the elderly.

(d) Outreach services.—Number of clients served: 200. Provide door-to-door canvassing and individual followup to reach older individuals not familiar with available programs. Referrals to available social service programs the elderly could benefit from.

(e) Geriatric services.—Number of clients served: 623. Provide continuity of care through regular schedule followup for chronically ill elderly, i.e., diabetics, hypertension, cardiac, paraplegic, TB, emphysema, leprosy, etc. Provide needed medical-dental care including followup and referrals to other health service facilities. Maintain complete and concise medical records and current information of eligible elderly. Provide information on communicable diseases, preventive care, other health problems including the administration of vaccines. Disseminate health-related information to the elderly and immediate family.

(2) Title III-C1, congregate meals.—Number of clients served: 180. Provide one complete hot meal, 5 days a week. An opportunity to meet old friends, and make new ones. Able to participate in other activities offered at the center. Information and referral to other social services agencies.

(3) Title III-C2, home-delivered meals.—Number of clients served: 170. Provide one complete hot meal, 5 days a week. Information and referral to other social service agencies.

(4) Title V, SCSEP (employment program).—Number of clients served: 56. In service training. Promote and assist in the transition of senior workers to private or other unsubsidized employment. Provide and promote part-time employment for low-income elderly.

(5) Title IV-C, legal services.—Number of clients served: 50. Provide legal advice and assistance on problems of importance to the elderly, who could not afford these services.

(6) Title XX, social services program (Social Security Act).—Number of clients served: 200. (a) Home maintenance services: Provide investigation of needs. Provide basic home maintenance. To identify safety and health hazards. Provide information and referral to social services agencies.

(b) Home-delivered meal service to handicapped. Provide one complete hot meal, 5 days a week. Provide nutrition counseling and education. Provide information and referral to social service agencies.

(c) Adult protective services.—Provide assistance to older individuals who demonstrate a need against abuse, neglect, or hazardous situation.

NATIONAL PARK SERVICE

The National Park Service has long recognized its responsibility to provide opportunities for all the Nation's citizens to participate in and enjoy the programs provided throughout its system. In fact, in 1979, the Service created a new Division of Special Programs and Populations with specific responsibilities to monitor and coordinate systemwide efforts on behalf of special groups such as disabled and elderly persons. Over the past few years, considerable action has taken place at the national, regional, and local park levels to fulfill this commitment. A number of our parks have developed specific programs for senior citizens. These programs include special activities such as day camps for seniors, the provision of senior centers, special tours and programs, as well as outreach efforts where park personnel go into convalescent hospitals and nursing homes to present programs usually provided at the park.

At the present time, efforts are being made to increase the numbers of older citizens in the Service's volunteers in the parks program. Another major effort of the National Park Service as it relates to senior citizens is the operation of the Golden Age Passport program. The Golden Age Passport is a free lifetime entrance permit to those parks, monuments, and recreation areas administered by the Federal Government which charge entrance fees, and is issued to citizens or permanent residents of the United States who are 62 years of age or older. It also provides a 50-percent discount on Federal use fees charged for facilities and services such as camping, boat launching, and parking. The Golden Age Passport was originally authorized in 1973 as a 1-year privilege, but was converted to a lifetime passport in 1975. Since that time, over 2.7 million lifetime passports have been issued.

In the past few years, the National Park Service has made increased efforts to make our facilities and programs more accessible to and usable by individuals who have mobility, visual, or hearing impairments. These program modifications have included adaptations for wheelchair users, captioning of some audio-visual programs for the hearing impaired, large type materials for persons with visual difficulties, and audio messages for the blind. Since a sizable percentage of the aging population experiences some of these disabilities, these modifications do make the parks more usable for the elderly as well.

The National Park Service also has the responsibility for managing the nationwide recreation plan, which includes the quinquennial Nationwide Recreation Survey (NRS), the land and water conservation fund, and the urban park and recreation recovery program. These programs have also considered the needs of the Nation's aging population.

The 1982-83 NRS continues on schedule under the joint sponsorship of the National Park Service, the Administration on Aging, the Forest Service, and the Bureau of Land Management. The NRS is the latest in a series of surveys—dating back to 1960—of the outdoor recreation pursuits, preferences, constraints, and concerns of the American people. All of this information will be analyzed by age cohort as well as by other demographic segments. In addition, the Administration on Aging is sponsoring a series of questions to be asked only of respondents age 60 and older. These questions seek information on the role or organizations in sponsoring recreation for the elderly and on the role of older Americans in transmitting outdoor recreation skills to succeeding generations. The results of the NRS will be available in 1984.

The land and water conservation fund has provided financial assistance to States since 1965 for the development and implementation of statewide comprehensive outdoor recreation plans (SCORPS). SCORPS include planning for recreation programs and services for the elderly. Also, as part of the SORP program, States prepare guidebooks that identify specific areas and facilities with special features to accommodate the needs of elderly persons. In addition, these plans frequently identify the modifications required by existing resources to make them more accessible to the elderly.

The two grant programs, the land and water conservation fund and the urban park and recreation recovery program, require States and communities participating to examine the recreation needs of senior citizens as part of their overall recreation planning and program development. Many facilities built or rehabilitated have provided access for senior citizens. The urban park program has given special priority, through the program's innovation grants, to projects providing programs to special populations including senior citizens.

Funding for the urban park program as substantially reduced this past year, however, approximately $8 million were available for innovation grants. Most of the grants awarded provided programing for the elderly as part of their overall program.

Ten communities were awarded grants, totaling $1,571,747, for programs specifically designed for senior citizens or that have specific program elements for seniors. The following is a list of these communities and a brief project description:

San Francisco, Calif.—Recreation and community services outreach program for Tenderloin and South of Market neighborhoods, senior citizens are an identified target group.

St. Louis, Mo.—Elderly recreation programing and access improvements at three city recreation centers.

Elizabeth, N.J.—Elderly recreation and community services programing through coordination with public housing authority.

Mohawk, N.Y.—Elderly recreation and physical fitness programing developed through YMCA.

Wood County, W.Va.—Elderly/handicapped programing at Mountwood Park-White Oak Village complex.

Oakland, Calif.—Outreach and recreation programing for elderly.

Pascagoula, Miss.—Development of an urban footpath with exercise stations for senior citizens in conjunction with city's senior citizen center.

Wilkes-Barre, Pa.—Coordinated progam to provide recreation and community services to senior citizens.

Revere, Mass.—Senior Citizen Park Maintenance Corps members train and work with youth and young adults in park mainenance.

Somerville, Mass.—Partnerships for the improved delivery of recreation services for the elderly.

Finally, the National Park Service is working closely with the Administration on Aging to coordinate efforts in an attempt to more fully provide for the needs of the Nation's elderly. Discussions are currently being held between the two agencies regarding cooperative activities that commit both agencies to promoting the highest level of access to, and utilization of, recreation and park resources by senior citizens. The National Park Service is proud of its accomplishments and is committed to continued efforts in providing opportunities for all Americans.

GEOLOGICAL SURVEY

This is in response to your memorandum of November 17, 1982, requesting information concerning activities in the Geological Survey which focus on opportunities for older people. The Geological Survey is proud of the fact that over 350 of its employees are reemployed annuitants, and a large portion of those employed are middle age or older. We believe in the real strengths of experience and knowledge built upon years of research and personal development; we believe that the necessary foundation for a comprehensive study of the Earth's past coupled with an ongoing search for its future resources lies in employees whose careers are in a constant state of growth. The former Directors, Assistant Directors, Division Chiefs, and others of our staff are here because they have no desire to stop the challenging work of their careers, and because the Survey provides sincere interest and support in their endeavors. The expertise which older workers possess is a fund from which younger employees can draw enrichment.

At the Geological Survey, programs which recognize the efforts of older workers tend to focus upon their achievements. To date since our last report, 206 employees have received 30-year service awards, and 69 employees have received 40-year service awards. Such achievements are a personal measure of productive career development.

On an informal, unofficial basis there are several very active retired employee groups. Sponsored by their former Divisions, the activities these groups initiate allow retirees to maintain contacts with colleagues and to continue to support their mutual interests in the Earth sciences. A great many retired employees are continuing their scientific research and exploration on an individual basis and are often asked to present their findings at professional gatherings.

As always, the Survey continues to practice sound personnel management policies with respect to age discrimination, and assures fair and full employment consideration for all persons.

In summary, we continue to be proud of all of our employees and consider the older ones to be particularly necessary for the success of our mission.

BUREAU OF MINES

In response to your November 17, 1982, memorandum, we have again reviewed the Bureau's activities in respect to the aging. As indicated in your memorandum, our input to this year's report is essentially the same as the last.

We continue to make use of highly specialized technical and scientific expertise through the frequent reemployment of annuitants. We have reviewed our internal and external employement policies and find no evidence of age discrimination. To the contrary, experience, technical expertise, and specialization which may often increase with chronological age are frequently of prime importance in filling Bureau vacancies. Individual retirement counseling continues to be available for interested employees.

BUREAU OF RECLAMATION

The Bureau of Reclamation has traditionally carried out programs which provide meaningful opportunities for older Americans principally in the areas of employment and recreation. We continue to support and encourage these programs throughout the Bureau.

The Bureau's employment policy stresses equality of opportunity for all Americans. Qualifications requirements are based on the required skills, knowledges, and abilities for each position. This can prove beneficial to senior citizens who possess long and extensive experience in the Bureau's water resource programs. Physical standards are kept at the minimum level needed for safe and effective performance. The Bureau employs older persons in a broad spectrum of occupations. We also utilize retired individuals in consultant roles, as members of boards and commissions, and as reemployed annuitants to provide expertise in a variety of Bureau programs.

The Bureau has participated in surveys to determine physical barriers which prevent or discourage access to facilities and offices. Facilities are designed and modified where possible to meet the needs of handicapped persons, including those who are senior citizens.

Opportunities are also available at Bureau facilities for water-oriented leisure activities such as fishing, boating, and camping which traditionally attract retired citizens and other older Americans.

The Bureau of Reclamation is committed to continue its efforts in providing opportunities beneficial to all persons including the aging population.

BUREAU OF INDIAN AFFAIRS

Although the Bureau of Indian Affairs does not receive a specific appropriation for assistance programs exclusively aimed at aged residents of Indian reservations, older Indians are beneficiaries of a range of Bureau services, including social services, housing services, law enforcement services, and Indian education programs.

Indian tribes wishing to administer special programs for tribal elders normally look to the Administration on Aging, Department of Health and Human Services, for grant funds to operate such programs. Title VI of the Older Americans Act is designed specifically to assist Indian tribes in providing services to older American Indians. Numerous tribes in all parts of the country are presently administering title VI programs.

The Bureau's Division of Social Services administers a program of financial assistance to eligible Indian people, one pertinent component of which is custodial care for adults. Custodial care is essentially nonmedical care and protection provided to an eligible client when, due to age, infirmity, physical or mental impairment, that client requires care from others in his or her daily living. This care may be provided in the most appropriate nonmedical setting, including the client's home, an institution, or other group care setting.

The Bureau also requests an annual appropriation of funds for social services administration, i.e., "all other social services." These particular funds are utilized to (a) administer the grant assistance program, (b) provide counseling services to social services clientele, and (c) assist tribes in development of social services programs. It is the Bureau's position that this appropriation for social services administration, i.e., "all other social services," provides budgetary authority to assist tribes to develop aging services programs. In this latter regard, the tribes may "band" or prioritize Bureau social services administration funds at the agency or tribal level so that these funds may be utilized for aging services program development. This "banding" or prioritization procedure would essentially result in the tribe shifting available funds from a low priority activity to a higher prioritized activity. The procedure does not provide additional money, but merely shifts money from one use to another.

OFFICE OF SURFACE MINING

The Office of Surface Mining has no mission-related programs which are exlusively oriented toward the aged. Consistent with our policy of nondiscrimination, the aged and others are provided equal access to Federal employment opportunities and those for which Federal funds are used at the local and State levels. All grant recipients are advised of the requirement to prominently post information regarding equal access and opportunity.

FISH AND WILDLIFE SERVICE

The Service is pleased to respond to a request by the staff assistant, Policy, Budget and Administration, for input to the congressional report on aging. The following is a synopsis of our activities for the elderly that have been planned or conducted in 1982.

The Service administers a large number of facilities, such as wildlife refuges and fish hatcheries where we can provide excellent recreational opportunities for the elderly. We have made many specific physical improvements to our facilities which provide easy and safe access to the buildings and grounds open to the public. We have provided convenient, close-in parking spaces to avoid long walks, modified curbs to provide access to sidewalks and walkways, lowered telephones for ease of use, and installed handrails and rest benches to aid the elderly and handicapped.

One example of a recent improvement which has received many favorable comments is the installation of extended walkways and platforms into the fishing ponds at the National Fisheries Center, Leetown, W. Va. This provides elderly and handicapped persons much easier access and unobstructed maneuverability while fishing. We have also installed gradual-incline walkways and trails at refuges to make it less strenuous to the elderly and handicaped to enjoy our nature trails. We also provide group tours by bus which allows comfortable and leisurely viewing of our scenic areas.

The Service clearly recognizes the value of older employees. Our basic personnel management practices includes a strict adherence to nondiscriminatory hiring and job retention. We have a long track record for providing work fulfillment opportunities beyond retirement by reemploying annuitants. The expertise, experience, and knowledge of these elderly individuals have been invaluable to the Service. We encourage and allow our older employees to fully participate in a special departmental medical program which provides periodic physical examinations at no cost to the employee. We provide preretirement counseling to help make the transition to retirement less traumatic. We utilize a significant number of part-time positions which in many cases make it possible for an older person to be productively employed.

I believe our programs and actions clearly demonstrate that we are committed to a continual awareness of the need to insure that the older person is provided ample opportunity to fulfill career and work needs, and to take maximum advantage of recreational activities. We are proud to be able to contribute to these goals, and will continue to remove barriers which prevent full participation by the older person.

Bureau of Land Management

This is in response to your memorandum of November 17, 1982, requesting a report on Bureau activities for the aging, planned and/or conducted in 1982.

In general, the Bureau of Land Management (BLM) does not single out any particular group (e.g., the aging) for special emphasis in its various programs. The many and varied cultural, recreational, and employment activities of BLM are designed for the general public with the enjoyment of all persons, rather than any single group, in mind. Consequently, no special emphasis is directed toward any single group. Consideration is given to all, including the handicapped, the aging, small children, etc., in BLM programs.

Specific examples of involvement of senior citizens in BLM programs is difficult to document as there is no central point in the Bureau for the gathering of information on the aging. However, the following examples are provided as indications of participation of the aging in BLM prlgrams during 1982:

—The senior community service employment program (SCSEP), established under title V of the Older Americans Act, was still functioning in early 1982, although at a diminished pace from 1981. Some 20 senior citizens participated in this part-time, minimum wage jobs program, primarily in Oregon and California. At the present time the program is inactive, due to reduced ceiling levels and lack of funding.

—The senior volunteer program averaged 30 participants on board per month bureauwide in 1982. During peak months nearly 40 older Americans took part in this formal volunteer program with BLM.

—General voluntary employment in accordance with the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1737) is common in BLM, and varies from district to district, depending on such factors as type of local activity on BLM lands, awareness and aggressiveness of local BLM management, availability of volunteers, etc. A good example of participation by the aging is in the Yuma District, Ariz., where every winter thousands of people, primarily older persons, relocate their mobile homes from points further north to BLM lands along the Colorado River. Some of these senior citizens volunteer for such activities as ground surveillance, traffic monitoring, recreational activity oversight, and dissemination of information. In other districts, of course, volunteer employment does not exist.

The Bureau of Land Management continues to be sensitive to the needs of the aging and receptive to their participation in the maintenance and enjoyment of our public lands.

ITEM 9. DEPARTMENT OF LABOR

January 26, 1983.

Dear Mr. Chairman: Enclosed is a summary of the programs and activities of the Department of Labor for 1982 related to aging.

Described in the report are programs administered by the Employment and Training Administration, the Employment Standards Administration, and the pension and welfare benefits program.

I trust this information will be of assistance to you in preparing your report, "Developments in Aging."

Sincerely,

Raymond J. Donovan, *Secretary.*

Enclosure.

Employment and Training Administration

INTRODUCTION

The Department of Labor, through the Employment and Training Administration, provides a variety of employment, training, and related services for the Nation's older citizens.

The need to assist older workers in obtaining jobs is related to a number of trends in our society:

—The difficulty older workers' experience in obtaining jobs because of such factors as discriminatory personnel policies, obsolete skills, limited training opportunities, and lack of confidence.

—The disproportionate impact of inflation on older workers because of increasing prices, fixed annuity incomes, and inadequate retirement income.

—The current and anticipated impact of funding problems of retirement income systems, including the social security system.

—The increasing number and proportion of older people, resulting from declining birth and death rates.

—The high incidence of poverty among older people (the Census Bureau reports almost 9.5 million people 55 and over classified as poor or near poor).

HIGHLIGHTS

Older Worker Activities—U.S. Department of Labor—1982

In 1982, the senior community service employment program (SCSEP) supported 54,200 positions, with an appropriation of $277,100,000. This maintains the previous fiscal year's program level.

Almost 26,000 people, aged 55 years and over were enrolled in the Comprehensive Employment and Training Act (CETA) titles II-B/C and VII during fiscal year 1982.

Through the third quarter of fiscal year 1982, the State employment service agencies placed 293,958 individuals age 40 and over in jobs, or 43 percent of all older workers referred to job openings.

Of the 473,327 veterans age 40 and over who applied for employment assistance through the third quarter of fiscal year 1982, 79,147 (almost 17 percent) were placed in jobs and 38,271 were counseled.

The Department of Labor's Employment and Training Administration's Office of Research and Evaluation continued to conduct a program of research, experimental and demonstration projects dealing with middle-aged and older workers. These projects are cited under Research and Development in this report.

Pursuant to the mandate of section 308 of CETA, the Department of Labor awarded a total of almost $600,000 to two prime sponsors for demonstration projects to develop replicable systems to promote the employment capabilities of older workers and to develop innovative private sector employment and/or training situations for the elderly worker.

OLDER AMERICANS ACT PROGRAMS

Senior Community Service Employment Program

The U.S. Department of Labor administers the senior community service employment program (SCSEP). This program authorized by title V of the Older Americans Act, offers subsidized part-time employment to low-income persons age 55 and above. Program participants work an average of 20 to 25 hours a week in a wide variety of community service activities and facilities, including day care centers, schools, hospitals, senior centers, and beautification, conservation, and restoration projects. In addition to subsidized community service jobs, SCSEP participants recieve yearly physical examinations, personal and employment-related counseling, job training, and referral to unsubsidized jobs. Approximately 15 percent of the participants in authorized positions are placed into unsubsidized jobs each year.

Activity under this program was, in earlier years, sponsored by a group of four national nonprofit organizations (Green Thumb, Inc., the National Council of Senior Citizens, the National Council on the Aging, and the National Retired Teachers Association/American Association of Retired Persons) and the U.S. Forest Service. Until July 1, 1977, they sponsored all local projects being conducted in 47 States, the District of Columbia, and Puerto Rico. The Department also awarded SCSEP grants directly to three State governments and four territories not covered by the national organizations (Alaska, Delaware, Hawaii, American Samoa, Guam, the Trust Territories of the Pacific Islands, and the Virgin Islands).

During the program year from July 1976 through June 1977, the SCSEP subsidized about 15,000 jobs. Financial support for that period was provided by a $55.9-million supplemental appropriation during the last quarter of fiscal year 1976. In that program year, funds were divided so that the national sponsors received 80 percent of the funding and the State governments 20 percent.

In subsequent years, the funding level of the SCSEP was increased, the number of subsidized jobs was expended accordingly, and the proportions of funds allocated to national and State sponsors were modified.

The fiscal year 1981 SCSEP appropriation of $277.1 million supported 54,200 positions during the July 1, 1981, to June 30, 1982, program year. This represented an additional 1,950 positions over the previous year. State governments received 55 percent of the new positions. Table I shows SCSEP performance from July 1, 1982, to June 30, 1982.

The fiscal year 1982 appropriation was provided in two installments. The first was $66,528,000 million for one quarter. The second appropriation was provided pursuant to the General Supplemental Appropriations Act of 1982. This amount was $210,572,000 and resulted in a total fiscal year 1982 appropriation of $277,100,000, which is sufficient funding to continue support for 54,200 positions. The General Supplemental Appropriations Act also changed the division of funds between State and national sponsors. The net effect of this was to change the proportion of funds, so the nationals received 78 percent and the States 22 percent.

Experimental Projects

The Older Americans Act was reauthorized for 3 more years by Public Law 97-115 on December 29, 1981. Section 502(e) was amended to require the Secretary of Labor to undertake some experimental projects with a small part of the title V appropriation. The experimental projects are to be concerned with second career training and placement of older workers in private sector employment. Recently, steps were taken to allow selected program sponsors to initiate such private sector activities as training and placement of older persons in new technology and growth industries, the development of job sharing and part-time jobs which meet the needs of older persons, and coordination of these activities with Private Industry Councils. These efforts will be carried out with existing funding.

TABLE I.—*Senior Community Service Employment Program—Performance Report for the 1981-82 Program Year (July 1, 1981 to June 30, 1982)*

Funding	$277,100,000
Enrollment levels:	
Authorized positions established	54,200
Unsubsidized placements	8,978
Summary of characteristics—persons actually enrolled as of June 30, 1981 (in percent):	
Sex:	
Male	33
Female	67
Education:	
8th grade and under	35
9-11	21
High school graduate or equivalent	29
1-3 years of college	11
4 years of college and above	4
Veteran	11
Ethnic group:	
White	67
Black	23
Hispanic	7
American Indian/Alaskan	1
Asian/Pacific Islands	2
Economically disadvantaged	100
Poverty level or less	85
Age:	
55-59	20
60-64	28
65-69	26
70-74	17
75 and over	10
Area of community service in which program participants were employed (in percent):	
Services to the general community	54
Education	12
Health/hospitals	4
Housing/home rehabilitation	2
Employment assistance	1
Recreation, parks, and forests	9

TABLE I.—*Senior Community Service Employment Program—Performance Report for the 1981-82 Program Year (July 1, 1981 to June 30, 1982)*—Continued

Area of community service in which program participants were employed (in percent):—Continued	
Environmental quality	2
Public works and transportation	5
Social services	11
Other	8
Services to the elderly	46
Project administration	3
Health and home care	5
Housing/home rehabilitation	3
Employment assistance	1
Recreation/senior citizens	9
Nutrition programs	12
Transportation	3
Outreach/referral	7
Other	3
Average hourly wage	$3.46

COMPREHENSIVE EMPLOYMENT AND TRAINING PROGRAMS

Persons in all working age groups have participated in activities under the Comprehensive Employment and Training Act (CETA).[1] The 1978 amendments to CETA strengthened the focus on the employment problems of older workers. Under title III, the Secretary of Labor was required to insure that prime sponsors' plans include details of specific services to be provided to individuals experiencing severe handicaps in obtaining employment, including those 55 years of age and older. Also included in title III was broad authority to focus a more equitable share of employment and training resources on older workers.

CETA Titles II-B/C and VII

Under CETA titles II-B and C, participants were provided with comprehensive work and training services, which included institutional and on-the-job training, work experience, job search assistance, and supportive services. The private sector initiatives program, conducted under title VII, provided demonstrations of alternative approaches to obtaining greater involvement of the private sector in employment and training of the disadvantaged. In carrying out this program, Private Industry Councils (PIC's), with representatives from industry, business, organized labor, community-based organizations, and educational institutions worked cooperatively with prime sponsors in improving access for all CETA participants to private sector jobs.

Table II presents the estimated numbers of persons in the upper age groups who participated in programs under Titles II-B/C and in the private sector initiatives program under title VII in fiscal year 1982. (The figures reported for fiscal year 1982 are estimates based on the previous year's experience, since actual fiscal year 1982 data are not yet available beyond the third quarter.)

TABLE II.—CETA ENROLLMENT ESTIMATES,[1] FISCAL YEAR 1982

Item	Total	Percent	Titles II-B/C		Title VII	
			Number	Percent	Number	Percent
Total participants	932,168	100.0	795,945	100.0	136,223	100.0
45 to 54 years	40,996	4.4	34,583	4.3	6,413	4.7
55 years and over	25,678	2.8	23,262	2.9	2,416	1.8
Total, over 45	66,674	7.2	57,845	7.2	8,829	6.5

[1] Based on actual data through June 30, 1982, and projections for the fourth quarter.

CETA Section 308

Title III of CETA, section 308, authorized programs to facilitate increased labor force participation of low-income persons aged 55 and over. Late in fiscal year 1982 the Department awarded two demonstration grants of approximately $285,000 each to the CETA-PIC sponsors in Broward County, Fla. and San Diego, Calif. These projects will permit the sponsors to undertake special efforts on behalf of low-income persons age 55 and over. The project plans include such activities as media campaigns, employer seminars, and individual corporate training and employment efforts for older workers.

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[1] CETA will be phased out during fiscal year 1983 and superseded by the Job Training Partnership Act on October 1, 1983.

The objective is to develop replicable systems to promote the employment capabilities of older persons and to develop innovative private sector employment and/or training situations for the elderly worker. The process of program development, promotion, and the establishment of flexible private sector training projects and employment situations with the participation of employers will be followed closely so that the results can be shared with other PIC-CETA sponsors.

THE FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

Background

The national network of public employment service local offices created by the Wagner-Peyser Act of 1933 offers comprehensive employment assistance to all jobseekers, including middle-aged and older jobseekers. Services include employment conseling, occupational testing, job development, labor market information, job placement, and referral to training and employment programs administered by State and local governments. Applicants in need of assistance beyond the scope of public employment service responsibility, such as vocational rehabilitation or veterans benefits information, are referred to the appropriate service provider.

Although the unemployment rate for middle-aged and older workers is lower than for the younger age groups, the duration of unemployment experienced by mature men and women who lose their jobs tends to increase with age. The Age Discrimination in Employment Act of 1967, as amended, recognizes the need for special assistance for workers who are at least 40 years of age but less than 70.

For purposes of recordkeeping and statistical reporting, the employment service uses age 40 [2] as a reference point for the term "older workers."

Accomplishments Through the Third Quarter of Fiscal Year 1982

As of June 30, 1982 (the date of the latest available statistics), State employment service agencies placed 293,958 individuals age 40-and-over in jobs, or 43 percent of all the older workers referred to job openings. The 40,229 older individuals placed as a result of job development efforts represented almost 14 percent of all applicants age 40-and-over placed in jobs. Almost 8 percent of all older applicants were referred to other agencies for services to enhance their employability. Of the 473,327 veterans age 40-and-over who applied for employment assistance at State agency local offices, 79,147, or almost 17 percent, were placed in jobs, and 38,271 were counseled. (See table III for details of employment service accomplishments for older workers through the third quarter of 1982.) In addition:

—All State employment service agencies are encouraged to participate in the 23rd annual observance of "National Employ the Older Worker Week" sponsored by the American Legion. In this regard, the State agencies collaborated with American Legion Posts, State and area agencies on aging, Comprehensive Employment and Training Act prime sponsors, Senior community service employment program grantees, and other public and private organizations concerned with expanding career and employment opportunities for middle-aged and older workers.

—The U.S. Employment Service is developing a "Technical Assistance Guide for Employment Services to Older Workers" to assist the public employment security agencies in providing service to middle-aged and older jobseekers. The "Guide" is also expected to be a practical and useful reference for State and area agencies on aging, affiliates of the National Council on the Aging, Inc., and other organizations administering employment and training programs for older workers under authority of the new Job Training Partnership Act and title V of the Older Americans Act.

—Two brochures were prepared to encourage consideration of older workers by employers, and inform older jobseekers of public employment services available locally.

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[2] This reference point was recently changed from 45 to 40 in accordance with Office of Management and Budget guidelines.

TABLE III.—EMPLOYMENT SERVICE ACTIVITIES TO ASSIST OLDER WORKERS, FISCAL YEAR 1982 THROUGH JUNE 30, 1982 (ALL SOURCES OF FUNDS)

Services to individuals by State employment service agencies	Individuals served		
	Total all ages	Age 40 and over	Age 55 and over
New applicants and renewals	10,965,283	2,095,209	559,087
Individuals referred to job openings	4,379,851	683,941	164,392
As percent of new applicants and renewals	39.9	32.6	29.4
Individuals placed in a job	2,008,930	293,958	74,191
As percent of individuals referred to job openings	45.9	43.0	45.1
As percent of new applicants and renewals	18.3	14.0	13.3
Individuals counseled	552,374	102,719	23,339
As percent of new applicants and renewals	5.0	4.9	4.2
Individuals placed after counseling	104,844	15.987	3,575
As percent of individuals counseled	19.0	15.6	15.3
As percent of new applicants and renewals	1.0	.8	.7
Individuals tested (aptitude, proficiency and other)	407,525	52,812	8,381
As percent of new applicants and renewals	3.7	2.5	1.5
Individuals referred to supportive services	681,145	159,703	45,999
As percent of new applicants and renewals	6.2	7.6	8.2
Individuals for whom job development contracts were made	1,184,381	260,094	70,273
As percent of new applicants and renewals	10.8	12.4	12.6
Individuals placed as a result of job development	262,058	40,229	9,875
As percent of new applicants and renewals	2.4	1.9	1.8
As percent of individuals placed	13.0	13.7	13.3

Source: U.S. Department of Labor, Employment and Training Administration, U.S. Employment Service.

RESEARCH AND DEVELOPMENT

The Office of Research and Evaluation of the Department of Labor's Employment and Training Administration conducts a program of research, demonstration and evaluation. In recent years, a number of the projects have been concerned with middle-aged and older workers.

Completed Projects

1. Exploring preretirement work options

This study examined a variety of possible employment options in the Wisconsin Civil Service for persons approaching retirement age and for those who had already retired but wanted to return to work part time. Most of the study participants found the reduced work schedule advantageous to their family life and health and also indicated that they were more satisfied with their jobs after their hours were reduced. The major disadvantage of reduced hours was perceived to be financial, because of decreased salary and potential loss in annuity benefits. Supervisors found that the schedules did not disrupt work and, therefore, were generally supportive of participants who reduced their hours in transition to retirement.

2. Retired teachers as tutors

This project demonstrated and assessed the effectiveness of utilizing the services of retired teachers as volunteers in a program to improve the reading and math skills of elementary school pupils in the District of Columbia. The project was designed to determine the degree to which retired teachers gain satisfaction and a sense of accomplishment by utilizing their lifetime skills as well as to measure the effectiveness of tutoring in improving the performance of students who need remedial assistance. Study results indicated that students benefited from the tutoring, and the retired teachers derived personal satisfaction from watching the students gain confidence and master assignments as their skills increased.

3. Retirement experience of nonsupervisory personnel

This study focused on the retirement experiences of nonsupervisory personnel who retired between 1968 and 1978 from three large American corporations (a large manufacturer, a chain store, and a public utility). It dealt with the decision to retire, planning for retirement, expectations about retirement, and post-retirement work experience. The findings were compared with findings from an earlier study of managerial, professional, and technical workers who retired from the same corporations. The major findings were that 24 percent of nonsupervisory personnel retired because of mandatory retirement policies. Reasons most frequently given for early retirement were poor health (for men) and "had worked long enough" (for women). About 25 percent of the respondents had some type of work experience after retirement, and most were well satisfied with their post-retirement jobs. The most important problems after retirement were inflation, health of retiree, and spouse's health.

4. Longitudinal study of the labor market experience of men

The fifth report on the national longitudinal surveys (a project that is ongoing) deals with a 10-year followup of men initially surveyed in 1966 when they were 45 to 59 years of age. Among the findings are:

(a) Mandatory retirement forced only a small minority of men out of jobs.

(b) Poor health forced eight times as many men out of jobs as mandatory retirement; and

(c) A larger proportion of blacks than whites left the labor force because of disability. The black/white difference is explained by the difference in earnings relative to disability benefits. Although decreasing, race discrimination caused labor market disadvantages for blacks. Most men who retire for reasons other than health are happy in retirement, and most middle-aged and older men who remain in the labor force enjoy relatively favorable positions.

5. Social security and the labor supply of older men

This study estimated the effects of social security and the associated earnings test on the retirement rates of men over 62. An analysis of national longitudinal surveys data indicated that changes in the earnings test between 1970 and 1974 had no measurable effect on retirement behavior. The study results also suggest that eliminating the earnings test will not increase labor supply but will increase the net cost to the Government of social security.

6. Demonstration of development and testing of job sharing (project JOIN)

A project to develop and test job sharing in the Wisconsin Civil Service system for persons wanting to return to work part time, for persons planning to retire, and for full-time employed persons who prefer to work part time. The study was designed to measure the productivity of those in conventional work situations and to measure the impact of creating less-than-full-time jobs on the balance of work unit in which persons sharing jobs were located. The study findings indicated that job sharing can be implemented successfully, and can result in benefits to the employing organization as well as to the workers.

7. Early retirement and the labor market dynamics of older workers

This research was done under a doctoral dissertation grant to study various factors pertaining to the retirement decision. The study concludes that considerations of health and adequacy of retirement benefits are the dominant factors in the decision to retire.

Ongoing Projects

1. National longitudinal surveys

Since 1966, the Department of Labor has funded the national longitudinal surveys, tracing the education, training, and labor market experiences of selected population groups at critical transition states in working life, specifically, youth entering the labor force, women reentering the labor force, and men in their preretirement and retirement years. The last group consists of 5,000 men who were aged 45 to 59 when first interviewed 16 years ago. The 15th year personal interviews with the men were conducted in July to September 1981, and a telephone survey is planned for the summer of 1983. The cohort of women was aged 30 to 44 when first interviewed in 1967. The 15th year personal interviews with the women were conducted in the summer of 1982.

2. An analysis of participation of older workers in employment and training programs and the effectiveness of these programs

This study will use the continuous longitudinal manpower surveys and the current population survey to examine the participation of older Americans in CETA programs and effectiveness of the program for older workers. These data provide comprehensive individual-level information on eligibles and program participants. In conjunction with the National Council on Aging (NCOA), participation in and the effectiveness of the senior community service employment program will be examined, using summary information in quarterly and annual reports of sponsors and individual level enrollment and termination information from NCOA data.

3. The effects of Government policies on opportunities for older Americans

This research is designed to examine the effects of specified changes in the Employees Retirement Income Security Act and of medicare cost shifting to employers of workers age 65 to 69. The researchers will first estimate employer costs using an actuarial cost model and then estimate employment effects using a set of estimated labor demand equations and a comprehensive model of the labor market.

4. Older workers and the market for part-time employment

This investigation will develop and test models of supply-demand interaction in the part-time labor market. Central to the analysis is the ratio of fixed to variable labor costs. Policy actions which affect this ratio will be evaluated for their impact on part-time work, especially for people 45 and older. The investigators will also use University of Michigan longitudinal research files to study hours-worked behavior as individuals age.

5. Innovative employment practices for older Americans

This study will report information concerning the form and structure of employment options, the key employer, and public sector policy variables influencing decisions to use options. Managers responsible for the design, administration, and modification of programs providing special employment options for older workers will be interviewed. Policymaking managers in government will be contacted to ascertain the role of government institutions in influencing public and private employer decisions in providing options for older workers.

6. Analysis of older worker response to layoffs, closings, and job changes

This research will examine the ways in which displaced older workers become reemployed, and how that process is affected by workers' characteristics, procedures used, and assistance received. The analysis will be based on a sample of displaced older workers who registered at selected employment service (ES) offices. This project will utilize the data base developed in current research on ES effectiveness.

7. Worker productivity and age

This research will document, quantify, and analyze which attributes and characteristics of older and younger workers are related to their productivity as measured by earnings. The research will use an empirical model based on previous labor market research and human capital theory. Complete work histories for 4,000 employees from a company's human resources information system and the national longitudinal surveys will be used in the study.

Projects 2 through 7 are jointly funded by the Employment and Training Administration and the National Commission for Employment Policy.

EMPLOYMENT STANDARDS ADMINISTRATION PROGRAMS

On July 1, 1979, the Equal Employment Opportunity Commission assumed enforcement responsibilities previously carried out by the Department of Labor under the Age Discrimination in Employment Act of 1967 (ADEA) as amended. The ADEA prohibits employment discrimination on the basis of age in private sector and State and local government employment. (The EEOC had assumed responsibility on January 1, 1979, for enforcement of the ADEA in the Federal sector, for which the Civil Service Commission had previous jurisdiction). Under Presidential Reorganization Plan No. 1 of 1978 which made these transfers, the Department of Labor continues to be responsible for research regarding older workers, including studying the effects of the 1978 ADEA amendments, and for educational activities for older persons.

Section 5 of the ADEA requires that the Secretary of Labor conduct an appropriate study of institutional and other arrangements giving rise to mandatory retirement. The 1978 ADEA amendments expanded the section 5 study to include an examination of the consequences of the amendments which raised the mandatory retirement age to 70 for most private sector and State and local government employees. Specifically, the amendments required that this study include: (1) An examination of the effect on private sector and non-Federal public sector employment of revising the upper age limit on coverage from 65 to 70; (2) a determination of the impact of revising or eliminating the current (age 70) upper age limit; and (3) an examination of the effects of the exemptions permitting mandatory retirement at ages 65 to 69 of tenured teaching personnel in institutions of higher education and of certain high policymaking employees. The former exemption expired on July 1, 1982, and the latter exemption remains in effect. The law required that the results of the Department's research be transmitted to Congress in an interim report (1981) and a final report (1982).

In 1979, the Department awarded a series of research contracts to enable the Secretary to fully implement the congressional directive in section 5 of the ADEA to conduct research related to involuntary retirement and the effects of the 1978 ADEA amendments. These research projects included: (1) A national survey of employer and employee responses to the ADEA provision raising the permissible mandatory retirement age from 65 to 70 (including an examination of employer retirement, pension, and personnel policies and the retirement plans of employees); (2) a major analytical study of the labor force consequences of raising the mandatory retirement age (including estimation of the effects on labor force participation of older workers, projections of long-term labor force consequences of raising or eliminating the mandatory retirement age, impact on job opportunities for younger and minority workers, employer utilization of the exemption for executive employees and institutional reasons for the establishment of mandatory retirement age standards); (3) a national survey and analytical study examining the consequences of the exemption in the law for tenured faculty members of institutions of higher education (including a national survey of universities and faculty members, analytical studies of faculty of hiring and retention, and projections of the consequences of raising the mandatory retirement age); (4) a study of the characteristics of older workers; (5) a study of flexible employment policies for older workers; and (6) a study of the legal application of the bona fide occupational qualification provision in the ADEA.

These research studies were completed in 1981 and study findings were incorporated in an "Interim Report to Congress on the ADEA Studies" which was transmitted to Congress in December 1981. A brief summary of the major findings from the studies appears below; however, much more detailed information is available in the 1981 interim report. It should be noted that, in accordance with these findings, the administration announced its support for legislation that will end mandatory retirement and eliminate the age 70 "cap" contained in section 12 of the ADEA for all personnel actions except hiring and promotion.

SUMMARY OF MAJOR FINDINGS: INTERIM REPORT ON STUDIES REQUIRED BY SECTION 5 OF THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967

Findings Related to Mandatory Retirement Policies

The studies examined three major issues: (1) The response of employers and employees to the increase in the permissible mandatory retirement age from 65 to 70, (2) the effect of mandatory retirement ages on labor force participation by older workers, and consequences for younger workers, and (3) prospective older worker labor force participation with mandatory retirement at age 70 and with elimination of mandatory retirement.

Employer and Employee Response to ADEA

In 1980, about half of the work force were covered by a mandatory retirement age (usually 70). After passage of the ADEA amendments, most employers that had a mandatory age increased it to 70 to conform to the law, but made few other changes in personnel or employee benefit policies. (Only 6 percent of all employees had their mandatory retirement age limit removed as a result of the ADEA amendments). Of particular significance were the findings that: (1) The increased mandatory retirement age did not result in increasing costs for performance evaluations since most firms with mandatory retirement already used a performance evaluation system; and (2) of the approximately 50 percent of employers who voluntarily provided pension benefits to workers who remained after the normal retirement age, very few chose to discontinue to retire at relatively early ages between 60 and 65 and they expected little change in this pattern in the near term irrespective of the higher mandatory retirement age. With a continuation of the early retirement trend, little expectation that retirement ages will change soon, and provision of continued incentives to early retirement, most employers do not anticipated changing their personnel and employee benefit policies in the near future in response to the increased mandatory retirement age. The major effect of the ADEA amendments on employees therefore was to require the adoption of a higher mandatory retirement age. The law did not generally result in employers changing other retirement-related policies.

The impact of increasing the mandatory retirement age to 70 on employee retirement decisions has been quite limited. Most employees continue to expect to retire between the ages of 60 to 65. Only 11 percent suggested any recent change in their retirement plans for any reason and only 1 percent suggested that they would retire later due to the higher mandatory retirement age in the ADEA. While retirement age plans may change over time they will not be changed immediately in response to an increase in the mandatory retirement age. Finally, the evidence from the studies suggested that with a higher mandatory retirement age (or no age whatsoever), employees may gradually delay their planned age of retirement by 1 to 2 years. However, over the past 20 years actual retirement ages have been consistently lower than planned ages. Nevertheless, the later age limit has provided some older workers with the opportunity to continue employment and thus contribute to the economy.

Mandatory Retirement Ages and Labor Force Participation by Older and Younger Workers

Study findings demonstrated that the existence of the prior age 65 mandatory retirement rule significantly reduced labor force participation of older workers. The Department's study and many other analyses demonstrate conclusively that mandatory retirement age policies reduce the labor force participation of 60 to 70 older workers. The Department projects that raising the mandatory retirement age to 70 will induce 250,000 more persons 60 to 70 years of age to have remained in the labor force by the year 2000. This represents an increase of about 5 percent of the total older work force.

An analysis of the consequences of raising the mandatory retirement age on younger, female and minority workers was also performed.

The results indicated that competition between older workers remaining employed and other "vulnerable" groups of workers was minimal and that problems such as youth unemployment and barriers facing minority workers would not be worsened by the change in the mandatory retirement age. A relatively small number of older workers are expected to continue working past age 65, and those that will do so will represent potential competition for a very small number of younger, female, or black workers. Overall economic trends and aggregate labor force demand are of far greater importance in influencing the employment levels of these groups than the effects of a change in the mandatory retirement age.

Labor Force Consequences of Eliminating the Mandatory Retirement Age

The Department of Labor's projections from the national studies of mandatory retirement, indicate that in the year 2000, total labor force participation by persons age 65 and over will have increased by about 5 percent (250,000 workers) as a result of raising the mandatory retirement age to 70. Projections further indicate that the complete elimination of mandatory retirement would result in an additional increase in labor force participation of approximately 200,000 workers. This represents an additional 5 percent increase in workers 65 and over. The DOL projections indicate that taken together, and assuming a continuation of current national retirement policies, the 1978 ADEA amendments and further legislation eliminating the mandatory retirement age would result in employment of approximately 450,000 additional older workers (aged 60 to 70) by the year 2000.

Overall, the Department's research has indicated that it is the financial benefits provided under the pension plans to which mandatory retirement rules are usually linked, that remain the important determinants of retirement age choice. Therefore, the long-term impact of eliminating a mandatory retirement age on the degree to which older workers will choose later retirement, depends heavily upon how private pension plan and social security retirement incentives may change to induce older workers to remain employed longer.

Mandatory Retirement Under Special Circumstances

Executive employees

The 1978 ADEA amendments included a provision which permits the mandatory retirement between ages 65 and 69 of bona fide executives and high policymaking employees if: (a) The employee is in the executive position for the 2 years immediately preceding retirement, and (b) the employee is entitled to an annual retirement pension of at least $27,000.

In enacting this exemption from the mandatory retirement age of 70, the Congress took notice of the potential problems corporations might encounter if they were unable to assure predictable retirement patterns for top executives, jeopardizing effective overall corporate management.

In order to assess the utilization of the executive exemption by business firms, one of the Department's ADEA studies—The National Survey of Employer and Employee Response to the 1978 ADEA Amendments—asked a series of questions regarding the exemption to about 3,000 firms in the Nation. In addition, case studies were conducted with a small group of firms to further investigate their use of the exemption.

The national survey indicated that 20 percent of all firms were using the exemption in 1980. The firms were usually large firms and manufacturing companies. An additional 20 percent were considering using the exemption, but had not as yet decided to do so. The remainder of the firms—60 percent—were not using the exemption. Firms using the exemption suggested that the major reason was assuring promotional opportunities and secondarily to achieve cost savings. Firms not using the exemption suggested that it was not needed because existing retirement patterns are satisfactory, with most executives retiring by age 65 and that there were too few executives in the firms to justify using the exemption. At present, it is estimated that the great majority of executives in the nation—75 percent—work for large firms with mandatory retirement policies and are covered under the exemption. Thus, it can be assumed that most executives in large firms who meet the legal definition for exemption can legally be subject to mandatory retirement at age 65.

Tenured faculty members at institutions of higher education

The 1978 ADEA amendments included a provision that permitted the mandatory retirement between ages 65 and 69 of employees serving under contracts providing for unlimited tenure at institutions of higher education. This provisions expired on July 1, 1982, and the permissible mandatory retirement age is now 70 for such employees.

This exemption was enacted because of concerns of university administrators that establishing an immediate mandatory retirement age of 70 when the 1978 ADEA amendments were enacted, would have resulted in reductions in hiring younger faculty including minorities and women, difficulties for university budget planners in immediately adjusting to increased costs for older faculty choosing to remain employed and difficulty with maintaining tenure agreements. The temporary faculty exemption was therefore designed to deter the mandatory retirement at age 70 provision until July 1, 1982, to permit colleges and universities with mandatory retirement policies to adjust to the higher mandatory retirement age. During the period of deferral, the Department of Labor was mandated to conduct a study of the consequences of the expiration of the exemption for higher educational institutions.

One of the ADEA studies examined the consequences for universities of the expiration of the tenured faculty exemption. The purpose of the study was to assess probable effects on university costs for retaining older faculty who would choose to continue employment and possible consequences in reducing the hiring of younger faculty members. Although the study could not accurately evaluate possible effects of removing entirely the mandatory retirement age, the direction of such effects was demonstrated.

The study findings indicate that the upward shift in the permitted mandatory retirement age from 65 to 70 will modestly increase costs and decrease new faculty appointments at colleges and universities. While institutions will be able to adjust to this change, the removal of any mandatory retirement age may pose more difficult adjustment problems.

The study findings indicated that in 1980, 52 percent of colleges and universities employing 68 percent of all faculty members already had a mandatory retirement age of 70 or above. However, only 20 percent of universities, employing 12 percent of all faculty, had no mandatory retirement age whatsoever. Most institutions using a mandatory retirement age other than 70 were private colleges and universities which continued to utilize an age 65 standard and appeared to be awaiting the expiration of the exemption before changing to an age 70 policy.

Study results indicated that raising the permissible mandatory retirement age from 65 to 70 would result in an upward shift in the age distribution of faculty members, somewhat higher institutional costs and declines in hiring rates, but this will be followed by a smooth adjustment to the new retirement age policy. Thus, in the short run the effects will be moderate while in the longer term, they will be hardly noticeable. The effects will occur over a 10-year period 1982-92, but will be concentrated in the first 5 years.

The study did indicate that a mandatory retirement age of 65 does decrease employment beyond age 65 for faculty members. It further demonstrated that with a mandatory retirement age of 70, on average, the expected retirement age of faculty would increase from 65.6 to 67 years. At the same time, an examination of available national data on actual faculty retirement age trends shows stable patterns over the past 5 years with most retirements taking place at ages 65 to 66, and a gradual increase in retirement at ages 60 to 64. Finally, information on expected age of retirement gathered from current faculty members indicates that relatively significant numbers expected to retire after age 65, but that the actual choice of retirement age will be influenced by availability of pension benefits.

Overall, the study findings show stable faculty retirement patterns and fairly stable enrollments in colleges and universities indicating adjustment to the expiration of tenured faculty exemption will have modest budgetary and personnel consequences for most colleges and universities.

Because of the difficulty of predicting future retirement age choices of faculty members, the DOL study was unable to systematically evaluate the potential consequences of elimination of any mandatory retirement age for colleges and universities. The consequences of taking this step are not predictable with present information. Since the current exemption expired in July 1982, data on the effects of raising the permissible mandatory retirement age in the entire higher education sector will not be available until this change has been in effect for several years. Therefore, a study should be conducted to ascertain the consequences of a mandatory retirement age of 70 and of eliminating the mandatory retirement age, for universities and faculty members.

In December 1982, the Department of Labor submitted its "Final Report to Congress on Age Discrimination in Employment Act Studies." The report contained a number of recommendations designed to strengthen the Age Discrimination in Employment Act so that the goals of the act—to promote employment of older persons based on ability rather than age; to prohibit arbitrary age discrimination in employment; and, to help employers and workers find ways of meeting problems arising from the impact of age on employment—can be more fully achieved. The recommendations are in two major areas: Legislative and policy; and education, information and research.

A. Legislative and Policy Recommendations

(1) Eliminate the mandatory retirement age by amending the Age Discrimination in Employment Act

The Department of Labor studies required by the Age Discrimination in Employment Act Amendments of 1978, indicate that mandatory retirement ages reduce the employment of older workers and result in arbitrary discrimination in employment based on age. The elimination of mandatory retirement will result in increased employment of older workers, but will not significantly affect employment opportunities of other labor force groups. Employers have not experienced major administrative difficulties or increased costs with mandatory retirement at age 70 and do not anticipate major changes in employee retirement patterns if mandatory retirement is eliminated. However, concern has been expressed about possible difficulties related to hiring and promoting employees aged 70 and older. The Department of Labor therefore recommends that the Age Discrimination in Employment Act be amended to eliminate any mandatory retirement age, but that prohibition of age discrimination in hiring or promoting individuals be limited to persons between the ages of 40 and 70.

Enacting such legislation will prohibit arbitrary discharge, demotion or salary reduction for all employees over 40 years of age and will effectively protect them from losing their jobs on the basis of age. The legislation would represent a fundamental improvement of the ADEA which would substantially increase protection against age discrimination for older employees.

(2) Retain the executive exemption in the Age Discrimination in Employment Act allowing compulsory retirement of certain executives at age 65 or over.

The executive exemption provision in the ADEA is being used by most large business firms in the Nation. A significant number of additional firms are considering utilizing the exemption in the near future. For those firms the exemption is very important in predicting retirement patterns, assuring promotions, and changing top management. The exemption is restricted to top executives and thus is applicable to only a small number of highly compensated employees. The exemption is particularly important for large firms with complex personnel systems where top management decisions are significant for the national economy. Retaining the exemption is therefore in the Nation's overall economic interest. The Department of Labor therefore recommends that the executive exemption in the Age Discrimination in Employment Act be retained and modified to remove the current limitation of the exemption beyond age 70 so that the exemption provision will conform to the proposed elimination of any mandatory retirement age.

(3) Retain a temporary exemption in the Age Discrimination in Employment Act at age 70 for tenured faculty members at institutions of higher education.

The elimination of any mandatory retirement age will have unpredictable consequences for the Nation's colleges and universities. While adjustment to a mandatory retirement age of 70 will result in some financial and hiring consequences for educational institutions, these will be manageable given current faculty retirement patterns which in general result in a somewhat later average retirement age than in the general population. An abrupt elimination of the mandatory retirement age altogether could impose unpredictable cost and hiring consequences on colleges and universities requiring rapid budgetary and personnel adjustments. There are also implications for the tenure system which have not been fully examined. Due to lack of experience with an age 70 mandatory retirement criterion (which became effective for all covered institutions only on July 1, 1982), predicting future faculty retirement patterns without any mandatory retirement age is extremely difficult.

The feasibility of eliminating any mandatory retirement age for tenured faculty employees at colleges and universities should be examined through a study of the consequences of such a policy for higher educational institutions. Therefore, the Department of Labor recommends that if the mandatory retirement age in the ADEA is eliminated, the tenured faculty exemption be continued at age 70 for a temporary period during which colleges and universities could evaluate faculty retirement trends, study the probable consequences of eliminating the mandatory retirement age and proceed to develop policies to minimize the consequences of the future elimnation of mandatory retirement.

(4) Congress should review major policy issues related to the Age Discrimination in Employment Act.

The Department of Labor studies mandated by the 1978 ADEA amendments and other studies and policy analyses have indicated that further information is needed to assess the consequences of the act and evaluate the merit of additional legislative changes in terms of effects on employers and employees. Issues of particular importance are: (a) The effects of providing pension credit for employment beyond age 65; (b) the administrative and cost consequences of hiring and promoting older workers at age 70; and (c) the consequences of current ADEA procedural provisions permitting jury trials and liquidated damage awards in age discrimination litigation.

B. Education, Information, and Research

The Department of Labor is aware of the need for dissemination of information to business and industry about older worker capabilities. However, it must be recognized that the development of suitable employment alternatives for older workers is in an early stage and much more information and research is needed to assist business firms in recognizing and implementing programs and policies for older workers. Achievement of long-term economic growth can be expected to result in the private sector. Therefore, increasing dissemination of information and encouraging implementation of nondiscriminatory older worker employment policies is an important national objective.

The Department plans to enhance its current efforts in these areas through:

(1) Sponsoring conferences in conjunction with business associations to provide information to their members on personnel and employee benefit policies for older workers and to provide information on techniques for hiring older job applicants.

(2) Developing and disseminating publications describing the capabilities of middle-age and older workers to business firms throughout the nation with the cooperation of employer associations, unions, and nonprofit organizations.

(3) Developing a program of technical assistance to private employment agencies and State/local government organizations to assist them in promoting the employment of older workers.

(4) Developing publications with information on the most successful employment policies for older workers.

PENSION AND WELFARE BENEFIT PROGRAMS

Pension and welfare benefit programs (PWBP) is a part of the Department of Labor's Labor-Management Services Administration. It is responsible for enforcing the Employee Retirement Income Security Act (ERISA). PWBP's primary responsibilities are for the reporting and disclosure and fiduciary provisions of the law.

Employee benefit plans, generally maintained by employers or by employers and unions, must meet certain standards set forth in ERISA. These standards are designed to insure that an employee actually will receive the benefit promised under the plan. ERISA applies only to private sector plans.

The requirements of ERISA differ according to whether the benefit plan is a pension plan or a welfare plan. Both pension plans and welfare plans must comply with certain provisions of ERISA governing reporting and disclosure to the Government and to participants (title I, part 1) and fiduciary responsibility (title I, part 4). Pension plans must comply with additional ERISA standards (contained in both title I, parts 2 and 3, and title II) including who must be allowed to be a member of a plan (participation), when a participant's right to a benefit becomes nonforfeitable (vesting), and how the employer is to finance benefits offered under the plan (funding).

The Departments of Labor and Treasury have responsibility for administering the provisions of title I and title II, respectively, of ERISA. The Pension Benefit Guaranty Corporation (PBGC) is responsible for administering title IV, which established an insurance program for certain benefits provided by specified ERISA pension plans.

REPORTING AND DISCLOSURE STANDARDS

ERISA requires that plans disclose to participants and report to the Federal Government information about plan provisions and financial status. Certain plans must submit an annual report. The report is a financial statement; defined benefit plans must also submit a certified actuarial report. The report generally includes a statement of plan assets and liabilities, a statement of the transactions involving conflict of interest situations and other information regarding the administration of the plan. Annual report forms are simplified for small plans, and a number of paperwork reductions have been instituted since ERISA's passage.

The annual report is submitted to the Internal Revenue Service (IRS) and shared by the ERISA agencies. This information is used for enforcement and research. The plan administrator submits the annual report to the IRS and furnishes participants and beneficiaries with a summary plan description (SPD) written in a manner calculated to be undestood by the average person. The SPD contains a description of benefits, the requirements for eligibility and procedures for presenting claims for benefits. In addition, participants may request, or in some cases, must receive a statement of their individual benefits. Reduction of unnecessary paperwork, to the extent consistent with assuring necessary information is submitted to enforce the law, was a top priority in 1982 and will continue to be so.

MINIMUM STANDARDS FOR PARTICIPATION AND VESTING

The IRS, for the most part, enforces the ERISA minimum standards. ERISA sets forth certain standards regarding the age and service requirements which an employee can be required to have completed before being allowed to participate in the employer's pension plan. The basic rule is that an employee cannot be denied membership in the plan, merely on account of age or service, if he or she is at least 25 years old and has worked for the employer for 1 year.

Certain other ERISA provisions govern when a plan participant must gain a nonforfeitable right to that portion of the retirement benefit provided by the employer's contributions to the plan. (The participant's own contributions are always nonforfeitable.) In this regard, the plan must provide that an employee gains a nonforfeitable right to this portion of his or her retirement benefit according to a schedule which is not less generous than one of the four set forth in ERISA. ERISA also contains rules on the rate at which participants must be allowed to "accrue" a benefit, i.e., the rate at which they are considered to have "earned" a portion of their ultimate retirement benefit. These standards basically are relevant to pension plans which provide participants a certain periodic payment upon retirement.

MINIMUM FUNDING STANDARDS

ERISA sets forth certain rules regarding the financing of pension plan benefits that basically apply to those plans which promise participants a defined periodic payment upon retirement. In plans of this type, the employer's contributions are determined actuarially (i.e., using certain assumptions concerning mortality, interest, turnover, etc.) to calculate how much is needed in order to insure sufficient funds to provide for the benefits promised by the plan. ERISA provides rules governing what sorts of actuarial assumptions and funding methods are appropriate and establishes penalties for failure to comply with these standards. These funding rules are enforced by the IRS.

FIDUCIARY STANDARDS

ERISA sets certain standards regarding the investment and utilization of plan assets with which fiduciaries of employee benefit plans must comply. These standards include that plan assets be invested "solely in the interest" of plan participants and beneficiaries and that plans be maintained for the exclusive benefit of the participants and their beneficiaries. ERISA provides that fiduciaries adhere to standards regarding the safeguarding and diversification of plan assets that would be followed by a "prudent" investor. ERISA also sets forth certain rules governing activities that (unless specifically exempted) may not be carried out by certain individuals and groups (including fiduciaries) who, because of having a potential conflict of interest with the plan, might cause the plan to operate in the interests of themselves rather than in the interests of the plan participants and beneficiaries. These activities are know as "prohibited transactions," and persons who violate them are subject to a tax imposed by the Internal Revenue Service.

Civil actions may be brought by the Secretary or plan participants and beneficiaries for a breach of fiduciary duty. The Department places great emphasis on enforcing these fiduciary provisions. In fiscal year 1982, it restored $34 million in plan assets and prevented an additional $53 million from being imprudently or otherwise illegally used.

PLAN TERMINATION INSURANCE

Title IV of ERISA establishers a benefit insurance program administered by the PBGC, an independent nonprofit entity with a board of directors consisting of the Secretaries of Labor, Commerce, and Treasury. This insurance program is applicable only to certain pension plans which promise a defined benefit upon a participant's retirement. Employers who maintain these covered plans are required to pay a per-participant premium to the PBGC to finance this coverage.

The guarantee program itself differs according to whether the plan in question is a single-employer plan or one maintained by more than one employer. In the case of a single-employer plan, the PBGC will guarantee, to a certain prescribed level, the payment of a participant's nonforfeitable benefit in plans which terminate with insufficient assets to meet their obligations to pay these benefits. In the case of a multiemployer plan, the PBGC also guarantees benefits, at a prescribed level lower than in the single-employer situation. In this case, however, it is the inability of the plan to pay participants their guaranteed amount rather than termination that triggers financial assistance.

RESEARCH AND DEVELOPMENT

PWBP conducts coordinated program of research through contracts and inhouse studies. The research program develops data on employee benefit plans which can be used as the basis for program modifications or policy decision. It also analyzes economic issues related to retirement decisions and income. The following study was initiated in 1982: Estimates of Participant and Financial Characteristics of Private Pension Plans, 1978.

The following studies were completed in 1982: (1) Financial Incentives for Early Retirement. (2) The Role of Employer-Sponsored Pension Plans in the Employment Contract. (3) Retirement and Saving Behavior. (4) An Analysis of Why Business Firms Offer Employee Pensions. (5) The Relationship Between Expected and Acutal Labor Supply Responses of Older Workers. (6) The Valuation of Private Pensions. (7) Male-Female Differences in Retirement Income: The Role of Private Pensions.

INQUIRIES

PWBP publishes literature and audiovisual materials which explains in some depth provisions of ERISA, procedures for plans to effect compliance with the act, and the rights and protections afforded participants and beneficiaries under the law. In addition, it deals with many inquiries from older workers. During fiscal year 1982, the national and field office staff of PWBP responded to over 84,000 inquiries from plan participants, beneficiaries, and other persons interested in the administration of plans. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension plans operate:

—What you should know about the pension and welfare law (English and Spanish versions).

—Know your pension plan.

—How to file a claim for benefits.

—Often asked questions about ERISA.

ITEM 10. DEPARTMENT OF STATE

DECEMBER 10, 1982.

DEAR MR. CHAIRMAN: The Secretary has asked me to reply to your letter of November 9, 1982. The Department of State played a major role in 1982 in the field of aging because we were the lead agency in the Federal Government coordinating preparations for the U.N. first World Assembly on Aging, which was held in Vienna, Austria, from July 26 to August 6, 1982.

We believe the plans for this important conference and the results of the conference itself are important enough to warrant their publication and dissemination in your annual report, "Developments in Aging: 1982," and so have enclosed rather extensive documentation on this subject. If more information is needed, please ask your staff to contact Ambassador John W. McDonald, Jr., U.S. Coordinator for the World Assembly on Aging.

With cordial regards,

Sincerely,

POWELL A. MOORE,
Assistant Secretary for Congressional Relations.

Enclosures.

REPORT OF STATE DEPARTMENT CONCERNING THE 1982 WORLD ASSEMBLY ON AGING

INTRODUCTION

For the first time in human history the nations of the world gathered in Vienna, Austria, from July 26 to August 6, 1982, to discuss an issue that besets all of mankind—the problem of aging. The U.N. World Assembly on Aging brought together 125 diverse and disparate governments to "develop policies designed to enhance the lives of the aging as individuals and to allow them to enjoy in mind and in body, fully and freely, their advancing years in peace, health and security * * * and with a view to enabling the potential of the aging to be fully realized * * *"

Out of the Assembly came the Vienna International Plan of Action on Aging, a 36-page, 118 paragraph document containing 62 specific action recommendations in the fields of health and nutrition, housing and environment, family, social welfare, income security and employment, education, data collection and analysis, training and research. Remarkably this complex but readable report was adopted by acclamation and no one of the 125 States present made a single reservation or explanation of vote on any one of the 118 paragraphs.

How was this rare unanimity of world opinion achieved?

DEMOGRAPHIC CONSIDERATIONS

One of the major achievements of the 20th century is the graying of the world's population. Because of the reduction in infant mortality, the decline in birth rates, improvements in nutrition, and the control of many infectious diseases, and better basic health care, people are living longer. We should all be proud of this accomplishment, at the same time recognizing that this unprecedent expansion of the aging population is having or soon will have major repercussions on the existing social, economic, and political value systems of every country in the world.

The U.N. Population Division produced its first major report on aging in 1973 and did a great deal of excellent new work for the World Assembly. Its latest findings are based on 1980 estimates and projections. The following rounded-out figures will put this global problem into perspective:

—In 1950, there were approximately 200 million people 60 years of age or over in the world.
—In 1970, this figure had grown to roughly 300 million.
—By the year 2000 this figure will have doubled to approximately 600 million.
—By the year 2025, the United Nations estimates there will be over 1.1 billion people in the world over 60.
—The thing to remember about this last figure is that 2025 is only 43 years from now, so that all of those people are on Earth today, having survived infant and childhood diseases.

Putting these figures another way:

—In 1970, about half of the people over 60 lived in the developing world.
—In the year 2000, roughly two-thirds of the aging will be in the Third World.

—By the year 2025, roughly three-fourths of the people over 60 will be in the developing world.

—By 2025, approximately 14 percent of the world's population will be over 60.

These startling figures both warrant and justify the U.N. concern about aging.

THE EARLY BEGINNING

It is fair to say, however, that the U.N. interest in aging was quite slow in developing. The first major speech on the problems of the elderly was given in the Plenary of the General Assembly in 1969 by Ambassador Pardo of Malta, and Malta has kept its interest in the subject to this day. In 1971, they initiated a resolution in the General Assembly asking the Secretary General to investigate the aged's socioeconomic and cultural role and status in nations of different levels of development and to report his findings and conclusions in 1973. This 1973 report was a critical one because it concluded that aging may be one of the crucial policy questions in the later third of the 20th century. As a result of this comprehensive report, a resolution was passed that year requesting the organizations concerned with aging to step up their activities and report to the General Assembly in 1977.

The U.S. Congress, and in particular Senator Church and Congressman Pepper, had long been interested in aging, and in 1977, were responsible for pushing similar resolutions through the Senate and the House of Representatives asking the President to instruct the U.S. Delegation to the United Nations to work with other delegations in order to launch a World Assembly on Aging. This goal was finally achieved on December 14, 1978, when the General Assembly adopted, by consensus, a resolution calling on the United Nation to organize a World Assembly on the Elderly in 1982. It is worth noting that after considerable discussion the title of the conference was changed in 1980 to "World Assembly on Aging."

THE BROADER U.N. CONTEXT

The General Assembly of the United Nations meets for 3 months each fall in New York and discusses as many as 200 different subjects on its varied agenda, covering the whole gamut of the world's problems. It was felt some years ago that perhaps a concentration on one single agenda item would produce more practical results, particularly in the area of economic and social development. In 1972, the United Nations sponsored the world's first single-agenda item conference. The subject was the environment, and the place was Stockholm. The conference was a great success because it had been carefully planned and brought policymakers and environmental experts together for the first time in a 2-week global forum and invited them to develop a plan of action, with recommendations for national, regional, interregional, and global action.

The idea caught on because it produced results. In 1974, there were two single-agenda-item conferences, on population, in Bucharest, and on food, in Rome. In 1975, the first global meeting on women and development took place in Mexico City. In 1976, there was a world conference on employment and basic needs in Geneva, and on housing in Vancouver. In 1977, the world gathered in Mar del Plata to talk about water, and in Nairobi to discuss deserts. In 1978, it was TCDC—technical cooperation among developing countries—in Buenos Aires. In 1979, there were two more conferences in this mold, science and technology in Vienna, and rural development in Rome. In 1980, the subject of women was discussed again, this time in Copenhagen. In 1981, there were global gatherings, in Nairobi, on new and renewable energy, and in Paris, on the problems of the least developed countries. The World Assembly on Aging should be viewed in this total context. It is the 15th and most recent. It is also a part of a long-range effort by the United Nations to focus world attention on global problems that generally have been ignored in the past. In each instance it is the hope of the conference organizers that the national policymakers who attend will be inspired to take national action to help resolve the problems discussed. The World Assembly on Aging is no exception to that general rule. It is hoped that the high substantive quality of the plan of action developed at Vienna, and the many practical recommendations made, will act as guideposts in the future and stimulate meaningful action at the national level.

PRECONFERENCE PREPARATIONS

The U.N. Secretariat undertook the most comprehensive preparations for a world conference that had ever been undertaken in U.N. history. They planned and organized 15 preconference regional meetings and helped with one worldwide meeting of nongovernmental organizations.

During 1980-82 the Secretariat organized seven regional, technical meetings, primarily of nongovernmental experts, in Malta, for the Arab World, San Jose, Bangkok, Lagos, Frankfurt Am Main, Kiev, and in Washington, D.C., for North America. This was a new and innovative idea and was tremendously successful. Each meeting prepared a report and these reports were then submitted to special intergovernmental meetings of the five U.N. Regional Economic Commissions. The regional meetings were in Manila, San Jose, Addis Ababa, Vienna, and Amman, and each produced a regional plan of action and recommendations that were forwarded to the central U.N. Secretariat in Vienna.

In December 1980, the U.N. General Assembly, very late in the game, approved the post of Secretary General for the World Assembly on Aging and authorized the creation of a 23-nation advisory committee to be responsible for conference preparations and suggested they meet three times before the actual Assembly began.

The Secretary General, William Kerrigan (United States), finally took office in June 1981, and three meetings of the advisory committee took place in August 1981, February 1982, and April 1982. The advisory committee's principal task was to review, debate, and amend the draft plan of action prepared by the Secretariat since it was to be the main action document to be considered by the World Assembly itself.

THE U.N. REGIONAL ECONOMIC COMMISSION

The special meetings of the U.N. Regional Economic Commission were vital to the success of the World Assembly because they raised the level of perception of the problems of aging by bringing governmental experts together for the first time, on a regional basis, and providing them with an opportunity to share their problems and experiences with representatives from neighboring countries. These meetings enabled national delegates to realize that their village, community or national situations were not unique. A friendly, understanding, and uncritical atmosphere was gradually created, making it easier to exchange ideas and to learn from one another.

A. The Developing World

Economic development means change. Rapid economic change can cause social upheavals that drastically alter traditional values as well as the role in society of the aged. When this social change occurs at the same time that the number and proportion of the aged is increasing, the problems of the aging are exacerbated.

Persuading many developing countries that the problems of aging are just over the horizon is not easily done. Their present staggering problems command their immediate attention. Typically, these countries have very youthful populations. Thus, there is an understandable preoccupation with such issues as youth unemployment and general economic expansion. The year 2000 seems very remote.

Many local government officials from the Third World state that traditional institutions, primarily the family, have provided, and will continue to provide for the aged in their country. However, in view of the worldwide phenomenon of increasing urbanization, a massive move from the village to the city, their faith in traditional solutions may not be well founded. In other words, as societies are dislocated by rural emigration and forces of modernization and industrialization, traditional institutions face increasing pressures in fulfilling their responsibilities. One cannot generalize, and the questions must be examined culture by culture and country by country, but the problem is rapidly getting out of hand in many areas of the world.

Growing awareness of the problems of aging was evidenced by the developing world in the three preparatory meetings held in Asia, Africa, and Latin America.

The first such meeting was that of the Economic and Social Commission for Asia and the Pacific (ESCAP) held in Manila, October 19-23, 1981. ESCAP produced a plan of action for the region that contained 34 recommendations directed toward national action. The main points of view that surfaced at the ESCAP meeting were the following:

(1) Eighty percent of the population is rural and has no social security coverage and no pension schemes.

(2) The family structure in many villages is crumbling because of migration to the cities.

(3) Institutionalization of the aging should be considered only as a last resort.

(4) The family is the basic resource for the care of the aging and should be strengthened through the provision of external services—by nongovernmental organizations and by the government, where possible.

The Economic Commission for Latin America (ECLA) had its preparatory meeting in San Jose, March 8-12, 1982. The draft program of action adopted by the conferees took note of urbanization and the growth of the population over 60 years of age. It stressed the economic problems facing the aging and called for a long-term view of the problems. In addition, the plan:

(1) Urged the strengthening of the role of the family as the primary social unit.

(2) Agreed that institutionalization of the aging was the last resort.

(3) Recommended that the aging actively participate in formulating policies affecting themselves.

(4) Supported the need for more education and training, especially for older farmers.

(5) Acknowledged the need for more active involvement of nongovernmental organizations in providing social services to the family; and

(6) Suprisingly, recommended the elimination of age restrictions on employment.

The Economic Commission for Africa (ECA) met in Addis Abada, March 1-4, 1982. The delegates, while noting potential problems, agreed that aging was not among Africa's major problems today, since the percentage of persons 60 and over would remain small for some time. However, they noted that this segment of the population was growing rapidly and should be taken into consideration in development planning.

(1) A central concern was the deterioration of the traditional extended family and its negative impact on care of the aged. A number of recommendations were aimed at strengthening the family unit and creating useful roles for the aged in it. The report put the matter beautifully when it said the family should be strengthened "in ways that insure the dignity, equality, and security of its aging members".

(2) The African Governments also agreed that the segregation of the aging into institutions "should be avoided and only used as a last resort."

(3) The conference recommended more education and training, stressed the need for more intergenerational relationships, and, as in Latin America, said that older persons should "have an opportunity to participate in decisions that affect their welfare."

(4) They urged solutions which would reflect and promote traditional African values.

It was fascinating to see how closely the views from Asia, also encouraging to realize that a recognition of the problems the world was facing in this area was becoming more widespread.

B. The Developed World

The Economic Commission for Europe (ECE), whose members are from Eastern Europe, Western Europe, and North America, held their preparatory meeting in Vienna, April 26-30, 1982. It is in Europe that the "aging of populations" is most significant. The proportion of people 60 years of age and over increased from 12.9 percent in 1950 to 16.7 percent in 1970, and is projected to increase to 19.5 percent by the year 2000. The meeting noted that that aging of populations will slow in the countries already greatly affected (e.g., Austria and Sweden), but there will be a substantial rise in Eastern and Southern Europe. The European countries as a whole have advanced programs for social security, geriatiric medicine, and social welfare, but the 33 governments present at the meeting took this subject quite seriously and developed a regional plan of action with 62 recommendations. Many of their concerns were similar to those of the developing world.

What was a particular interest, however, was that delegates from a number of Western European countries acknowledged that many of the approaches they were following today with regard to the aging were not working satisfactorily. Many Western countries were currently reviewing their policies and plans because costs were too high and they were experiencing financial difficulties. In other words, no country has all the answers and all countries can learn from one another.

THE ROLE OF NONGOVERNMENTAL ORGANIZATIONS

In the non-Communist, developed world the nongovernmental organizations (NGO's) play a key role in developing national and local programs for the aging. They are organized, highly motivated, and frequently well funded. The NGO's also play a significant role on the international level. An NGO Committee on Aging was organized in New York in 1977, and meets regularly. The committee maintains close contact with the U.N. Secretariat as well as with other NGO groups. There is also an NGO Committee on Aging in Vienna which meets regularly and maintains liaison with the U.N. Centre for Social Development and Humanitarian Affairs. The New York and Vienna committees work in close cooperation with one another.

An NGO forum on aging was held in Vienna, March 29–April 2, 1982, and some 350 people from 43 countries representing 159 organizations participated. This was a unique gathering. For the first time in the history of these single-agenda-item global conferences, NGO's gathered before the U.N. meeting to develop their own substantive action plan which was then submitted to the U.N. Secretariat and presented to the World Assembly itself as a formal NGO document. In addition, there were a number of NGO's at the Assembly itself as official observers and unofficial lobbyists. In fact 22 NGO's spoke in the Plenary, a record.

In the United States, NGO's are particularly important. There are approximately 40 national organizations for the aging throughout the country, and their total membership is about 18 million. The American Associatión of Retired Persons alone has 13.5 million members and the National Council of Senior Citizens has 4 million. They have a dedicated and vigorous membership, and they constitute a real political force that the Congress and the administration bear in mind when formulating policies and programs.

THE WORLD ASSEMBLY ITSELF

Preconference consultations among governments took place in Vienna on July 24 and 25, 1982, in order to consider and recommend to the Assembly a number of organizational and procedural matters.

The World Assembly on Aging opened with a fanfare on July 26, in the magnificent Hofburn Palace, the center of Vienna. After remarks by Mr. Jean Ripert, U.N. Director General for Development and International Economic Cooperation, Dr. Kirch-schlager, President of Austria, addressed the 2,000 delegates from 125 countries. Dr. Firnberg, Austrian Minister for Science and Research, was elected President of the Assembly.

Most of the time of the Plenary was taken up by the 132 speeches from heads of delegations, representatives from the U.N. specialized agencies, and nongovernmental organizations.

The real work of the conference took place in the main committee, which was very ably chaired by Dr. A.H.B. de Bono of Malta. The main committee was charged with reviewing the draft plan of action which had been prepared initially by the office of the Secretary General for the conference and reviewed by the 23-nation advisory committee. Some 200 written and oral amendments to the text were tabled in the main committee. Interestingly enough, no delegation attacked the draft plan or its framework; all of the amendments were designed to strengthen the plan and to make it more specific or detailed in its recommendations.

It is important to remember that the delegates were trying to design a global document that would be acceptable to all nations but which would be detailed enough to provide all countries with ideas and recommendations which could be carried out at the national level. The plan of action was not mandatory in character. Its strength would lie in the unanimity of agreement reached, and the personal dedication of the participants to take these recommendations home and try to implement as many of them as possible in their own national surroundings.

There were hard, tough, and long negotiations in the main committee for the entire 2-week period. Finally, the night of August 5, the main committee accepted the amended plan of action as a whole, without a vote, and forwarded the text to the Plenary. On August 6, the plan of action was dopted by the Plenary with a burst of applause. No country reserved on any paragraph. A remarkable achievement.

One of the unusual political achievements of the conference was the actual withdrawal of nine different resolutions from the Plenary's consideration by the various sponsors. The resolutions had been designed to highlight or emphasize one or another particular aspect of the plan of action the sponsors happened to favor. Delegates finally agreed to let the plan speak for itself. It now stands alone as the principal achievement of the World Assembly on Aging.

THE PLAN OF ACTION

The international plan of action on aging consists of a brief preamble, a foreword, an introduction setting forth the demographic background of the subject, as well as certain humanitarian and development aspects of aging, and then moves quickly to the section on principles which is the real heart of the document. The rest of the plan is an elaboration of these principls. There are individual sections on health and nutrition, housing and environment, family, social welfare, income security and employment, education, data collection, training and research. These sections contain 62 specific recommendations for national action. Finally, there is a section giving recommendations for implementation at the global level and to international organizations. It lays out a U.N. structure for followup action.

An examination of a few of the principles will give the reader some of the flavor of this very readable, very solid, substantive document on aging.

The first paragraph contains the very umbrella sentence that makes the rest of the section possible: " * * * the formulation and implementation of policies on aging are the sovereign right and responsibility of each State." It then goes on:

—The family, in its diverse forms and structures, is a fundamental unit of society linking the generations and should be maintained, strengthened, and protected, in accordance with the traditions and customs of each country.

—The spiritual, cultural, and socioeconomic contributions of the aging are valuable to society and should be so recognized and promoted further. Expenditure on the aging should be considered as a lasting investment.

—Governments and, in particular, local authorities, nongovernmental organizations, individual volunteers and voluntary organizations, including associations of the elderly, can make a particularly significant contribution to the provision of support and care for elderly people in the family and community. Governments should sustain and encourage voluntary activity of this kind.

—The aging should be active participants in the formulation and implementation of policies, including those especially affecting them.

—Aging, in addition to being a symbol of experience and wisdom, can also bring human beings closer to personal fulfillment, according to their beliefs and aspirations.

—Governments, nongovernmental organizations, and all concerned, have a special responsibility to the most vulnerable among the elderly, particularly the poor, of whom many are women and from rural areas.

"* * * A fundamental principle in the care of the elderly should be to enable them to lead independent lives in the community for as long as possible."

CONFERENCE FOLLOWUP

The principles and recommendations laid down by the Assembly are impressive, but what happens next, now that the conference is over?

The advisory committee and the delegates at Vienna gave a great deal of thought to that problem. Admittedly, most of the action will have to take place at the national level and it will be incumbent on government administrators as well as representatives of nongovernmental organizations to make things happen in their country or in their community.

It was felt necessary, however, to create a framework for action at the global level which could act as a prod or a conscience to governments and could also provide technical and financial assistance to those nations and institutions in the Third World who wanted help.

Four specific ideas were proposed in the plan of action which, taken together, could provide the structure needed to make this plan a major instrument for change and hence a great success:

(1) An intergovernmental mechanism was needed which had the authority to oversee implementation of the Assembly's recommendations. The conference proposed that the 36-nation Commission on Social Development, one of the six commissions of the U.N. Economic and Social Council, be designated as the body to review the implementation of the plan every 4 years and to make proposals for updating the plan, as considered necessary. The Commission's findings would be forwarded to ECOSOC and to the General Assembly for consideration.

(2) A U.N. interagency mechanism for coordination was needed to stimulate concern and interest on the part of the specialized agencies and to insure there was no program overlap or duplication. The Assembly asked the U.N. Administrative Committee on Coordination, which is chaired by the Secretary General of the United Nations, and on which sit all of the Directors General of the specialized agencies of the U.N. system, to continue their liaison and coordination efforts in order to implement the plan. The International Labor Organization, the World Health Organization, the U.N. High Commission for Refugees, the U.N. Center for Human Settlements, and the U.N. Fund for Population Activities, among others, all made very meaningful contributions to the preparations for the World Assembly, all have active programs and projects in this field, and, it is hoped, will continue to be active; hence the need for coordination.

(3) The matter of a focal point in the U.N. system for conference followup was critical to the success of the Assembly. The conference recommended that the U.N. Center for Social Development and Humanitarian Affairs in Vienna serve as the focal point for the implementation of the plan of action. The delegates asked that the Center be strengthened to better carry out its role and the Secretary General was requested, within the existing global resources of the United Nations, to give due consideration to the provision of appropriate increased resources to the Center for this purpose.

(4) Last, the issue of financial support was most critical. In fact, this was the single most contentious substantive issue in the whole Assembly.

In December 1980, the General Assembly requested the Secretary General to establish a voluntary fund for the World Assembly on Aging and to inform member States of the existence of the fund. The United States was the first contributor and put $250,000 into the fund.

In December 1981, the General Assembly requested the Secretary General to use the trust fund to encourage further interest in the field of aging among developing countries, particularly the least developed among them, within the context of the World Assembly on Aging. The United States contributed another $400,000 to the fund.

The 1980 resolution was clearly intended to provide funds to the Secretariat to help prepare for the conference. The 1981 resolution began to look beyond the conference to the future needs of the Third World in this field. That was the heart of the issue. The United States, France, and the Developing World, wanted the trust fund to be converted into a long-term voluntary fund designed to help older persons in the Third World. The Swedes and the Soviets, Australia, Canada, and the other Nordic Countries wanted the fund to cease to exist when the World Assembly completed its work on August 6, 1982.

The United States viewed the continuation of the trust fund as the most important practical result coming out of the World Assembly and lobbied intensively to make that happen. It was finally decided that the fund would be continued in order to meet the rapidly increasing needs of the aging in the developing countries, that the payment of voluntary public and private contributions should be encouraged and that the fund should be administered by the Center for Social Development and Humanitarian Affairs.

In spite of its short life, the trust fund has a remarkably broad base of political support. Over 30 countries from all regions of the world have contributed $1½ million to the fund. Its supporters hope that both the political as well as the financial support will continue to grow. Certainly the need is there.

THE GENERAL ASSEMBLY OF THE UNITED NATIONS

The rules of the United Nations require that all recommendations arising out of a global conference under U.N. auspices must be referred to the General Assembly for final approval before they are considered official. The Vienna Plan of Action was referred to the Third or Social Committee of the 37th General Assembly, meeting in New York from September to December 1982.

The results of the Vienna conference were discussed by the Third Committee from October 18 to October 29, as part of a cluster of social issues dealing with youth, the disabled, and the aging. One hundred and twelve governments spoke to these subjects. Again, the general debate was remarkably free of polemical statements and dealt in a thoughtful, substantive manner with both the national and the international aspects of aging. The chairman of the Third Committee, Mr. Rodrigues of Brazil, called this 2-week period "an outstanding debate." No formal proposals were made to amend the Vienna Plan of Action. A resolution endorsing the plan, and all of its recommendations were adopted unanimously by the Plenary of the General Assembly on December 3, 1982. The recorded vote was 149-0-0.

CONCLUSION

Why was the World Assembly such a success? Obviously there were a number of reasons, but one must put the very able leadership of Mr. Kerrigan, Secretary General for the Assembly, and the efforts of his hard-working, dedicated staff at the top of the list. The preconference meetings were invaluable in raising governmental awareness to the problem. The solid documentary and personal support of some of the specialized agencies was important, substantively. The visits by the Secretariat to member States to stimulate interest, the public relations effort, and the very high caliber of the draft plan of action presented to the main committee for consideration were all important parts of the successful whole. The strong supportive role of nongovernmental organizations and their plan of action were most helpful.

RESOLUTION PRESENTED TO THE U.N. GENERAL ASSEMBLY AND ADOPTED UNANIMOUSLY ON DECEMBER 3, 1982

QUESTION OF AGING

The General Assembly,

Recalling its resolution 33/52 of 14 December 1978, in which it decided to convene a World Assembly on Aging to call worldwide attention to the serious problems besetting a growing portion of the population of the world and to provide a forum to launch an international programme of action aimed at guaranteeing economic and social security to older persons, as well as opportunities for them to contribute to national development,

Recognizing that increasing longevity is a biological achievement and a sign of progress, and that the aged are an asset and not a liability to society because of the invaluable contribution they can give by virtue of their accumulated wealth of knowledge and experience,

Bearing in mind that countries gathered in the World Assembly on Aging reaffirmed their belief that the fundamental and invaluable rights enshrined in the Universal Declaration of Human Rights apply fully and undiminishedly to the aging, and recognize that the quality of life is no less important than longevity, and that the aging should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfilment, health, security and contentment, appreciated as an integral part of society,

Convinced that the Vienna International Plan of Action on aging adopted by the World Assembly on Aging,[1] must lead to developing and applying, at the international, regional and national levels, policies designed to enhance the lives of the aging as individuals and to mitigate, by appropriate measures, any negative effects resulting from the impact of the aging of populations on development,

Recognizing that the plan of action should be considered an integral component of the major international, regional and national strategies and programmes formulated in response to important world problems and needs,

Recalling its resolutions 35/129 of 11 December 1980, in which it established a trust fund for preparatory and followup activities of the World Assembly on Aging, and 36/20 of 9 November 1981, in which it requested the Secretary-General to use the trust fund to encourage further interest in the field of aging among developing countries, particularly the least developed among them, within the context of the conclusions and recommendations of the World Assembly on Aging,

Acknowledging the role played by the United Nations and the specialized agencies through their efforts in the field of aging and the need to strengthen this role in order to make the implementation of the recommendations of the Plan of Action effective,

Emphasizing the importance of the Vienna International Plan of Action of Aging and stressing the spirit of cooperation that prevailed during the World Assembly on Aging,

Expressing appreciation to the Government of Austria for hosting the World Assembly on Aging,

Having considered the report of the World Assembly on Aging, held at Vienna from 26 July to 6 August 1982,

1. Takes note of the report of the World Assembly on Aging;[2]
2. Endorses the Vienna International Plan of Action on Aging contained in the report and adopted by consensus at the World Assembly on Aging;
3. Affirms that aging should be considered in the context of economic, social and cultural development, as well as in the context of international strategies and plans;
4. Calls upon Government to make continuous efforts to implement the principles and recommendations contained in the plan of action as adopted by the World Assembly on Aging in accordance with their national structures, needs and objectives;
5. Requests the Secretary-General to take the necessary steps to ensure that sufficient resources within reasonable limits are made available for the effective implementation of, and followup action to, the plan of action as well as to maintain the

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[1] "Report of the World Assembly on Aging, Vienna, 26 July to 6 August 1982" (U.N. publication, sales No. E.82.I.16), chap. VI.

[2] "Report of the World Assembly on Aging, Vienna, 26 July to 6 August 1982" (U.N. publication, sales No. E.82.I.16).

momentum generated by the World Assembly on Aging; in doing so, the Secretary-General should make every effort to reallocate existing global resources;

6. Also requests the Secretary-General to take such steps as may be appropriate for the necessary strengthening of activities in the field of aging at the central and regional levels of the United Nations as set forth in the plan of action;

7. Further requests the Secretary-General to strengthen the international network of existing information, research and training centres in the field of aging in order to encourage and facilitate the exchange of knowledge, skills and experiences, as well as technical cooperation among countries within various regions;

8. Urges the Secretary-General to implement the recommendations concerning the international cooperation with respect to aging, as well as the assessment, review and appraisal of the implementation of the plan of action, using the Centre for Social Development and Humanitarian Affairs of the Secretariat as the focal point;

9. Requests the Secretary-General to continue to use the trust fund to meet the rapidly increasing needs of the aging in the developing countries, in particular in the least developed ones;

10. Also requests the Secretary-General to use the trust fund to encourage greater interest among developing countries in matters related to aging and to assist member States, at their request, in formulating and implementing policies and programmes for the elderly; further requests the Secretary-General to use the trust fund for technical cooperation and research related to the aging of populations and for promoting cooperation among developing countries in the exchange of relevant information and technology;

11. Appeals to member States to make voluntary contributions to the trust fund;

12. Urges the United Nations Fund for Population Activities, in cooperation with all organizations responsible for international population assistance, to strengthen its assistance, within its mandate, in the field of aging, particularly in developing countries;

13. Requests the Economic and Social Council, through the Commission for Social Development, to review the implementation of the plan of action every 4 years, beginning in 1985, and to transmit its findings to the General Assembly;

14. Invites the specialized agencies concerned to cooperate with the Secretary-General in the implementation of the plan of action within their fields of competence;

15. Invites also the intergovernmental organizations and nongovernmental organizations concerned to continue to give attention to major issues related to aging and to coordinate their work with the United Nations, particularly in view of the need for well coordinated activities for the implementation of the plan of action;

16. Requests the Secretary-General to report to the General Assembly at its thirty-eighth session on the progress achieved in implementing and following up the plan of action and to include in his report an account of project activities financed by the Trust Fund;

17. Decides to include in the provisional agenda of its thirty-eighth session a single item entitled "question of aging" to replace the items "question of the elderly and the aged" and "World Assembly on Aging."

REPORT OF THE U.S. DELEGATION

I. BACKGROUND

With over 300 million persons 60 years or older in the world today, a number which will increase to something over 600 million by the end of the century, governments are faced with an unprecedented situation calling for aggressive and imaginative economic and social policies to deal with this new reality.

It was in recognition of the importance of this developing problem that the U.S. Senate and the House of Representatives adopted resolutions in 1977 urging that the President instruct the U.S. delegation to the United Nations to call for a World Assembly on Aging to meet not later than 1982. This proposal was conveyed to the United Nations, and in 1978, with the delegations of the United States and Malta as the prime movers, the thirty-third regular session of the General Assembly adopted Resolution 33/52 on December 14, calling for the WAA to meet in 1982.

II. SCOPE AND PURPOSE OF THE WAA

The scope and purpose of the WAA was elaborated by a further General Assembly Resolution (35–129) in 1980, to include the following:

—To focus the attention of governments on issues of aging of importance in designing policies and programs for economic and social development in both developed and developing countries.

—To provide an international forum for an exchange of views among governments on the ways and means of dealing with issues of the aging, including the machinery required for legislative and administrative actions.

—To identify specific aging issues and to consider methods to meet the need for action at the national, regional, and international level, and to consider, in particular, how countries can, through increased international cooperation, derive benefit from the knowledge and experience already acquired regarding the various issues of the aging; and

—To focus attention on and to encourage wider participation in and support for present and future activities and programs of U.N. organizations and other international organizations related to aging and to give them guidelines and directions.

The WAA is the 15th in a series of single-topic global conferences held by the United Nations since 1972, which deal with subjects of worldwide concern, such as the human environment, population, food, women and development, water resources, and new and renewable sources of energy. The basic objective of the U.N. global conferences has been to focus world attention on a single problem area with the view to stimulating political action on that area, especially at the national level but also, where appropriate, at the regional and international levels.

Superficially, population statistics might suggest that problems related to the aging are basically problems for the developed countries. The percentage of older persons in the total population of the industrial countries will increase from 14.7 percent in 1975 to 17.5 percent in 2000, whereas the comparable figures for the countries of the developing world are 6.1 and 7.5 percent. This discrepancy, however, is deceptive. For the same period, the percentage increase of the aging in the total population of the industrial countries is only 39 percent, whereas for the developing countries, already struggling with the monumental task of meeting the basic requirements of their peoples, the comparable increase is 100 percent. Coping with the implications of an aging population is, therefore, worldwide and imposes compelling demands on both developed and developing countries.

III. U.S. PREPARATIONS FOR THE WAA

The Office of the U.S. Coordinator for the WAA, headed by Ambassador John W. McDonald, Jr., was established in the Department of State in July 1980, to coordinate U.S. preparations for the WAA. In the spring of 1981, a Federal Interagency Committee on Aging (FICA) was established, consisting of representatives from all of the principal departments and agencies having responsibilities relating to the aging to provide coordinated U.S. Government preparations for the Assembly. FICA, which also included membership from the Congress, met regularly to discuss and approve each stage of U.S. preparations. Principal contributions came particularly from agencies of the Department of Health and Human Services, the Department of Education, the Department of Labor, the Department of Housing and Urban Development, and the Department of State.

Within the general goals of educating national planners and raising the international level of concern over the problems of elderly persons, FICA agreed that the following approach should guide U.S. participation in WAA:

(1) While the United Nations performs as an essential catalyst at the international level, active policies and programs must be developed and implemented by member governments at the national and local levels.

(2) Countries should be encouraged to focus on the problems related to their aging populations now, and not postpone their consideration on the mistaken assumption that attendant problems are too far in the future.

(3) Developing countries in particular should be discouraged from any assumption that aging is primarily a developed country phenomenon.

(4) The aged should be recognized as a valuable social and economic resource, representing an immense pool of talent that can be tapped for the benefit of society as a whole.

(5) The aged themselves should participate in the planning and implementation of programs directed toward their benefit in order to insure the development of realistic programs for the aged, responsive to their own needs, interest, and preferences.

(6) The goal should be to maintain an age-integrated society in which age discrimination and involuntary age segregation for all age groups are eliminated, and mutual respect and support between generations are strengthened.

(7) As long as possible, older persons should be encouraged and permitted to retain their independence in their communities and continue to live in their own homes; institutionalization should be the solution of last resort.

(8) The family should remain the primary source of care and concern for the aging.

(9) Personal fulfillment should be a specific goal incorporated in the plan of Action.

(10) Recruitment of professionals working with the aged should stress the need for gerontological and geriatric education and training.

(11) In the development of policies and progress for the aged, more attention should be given to older women, intergenerational linkages, employment of the aging, and volunteerism.

(12) As important channels for the direct expression of older persons' needs and interests, NGO's representing and serving the interests of the aging are uniquely equipped to develop and manage programs for the aging, and should be encouraged to continue and expand their activities.

All of the global U.N. conferences, beginning in 1972 with the U.N. Conference on the Human Environment, have, in addition to substantive issues, been concerned with the institutional modalities for giving effect to the recommendations emerging from the conference. Thus all have considered (1) the question of an appropriate intergovernmental mechanism to oversee the implementation of conference recommendations; (2) the desirability of intersecretariat and interagency coordination among various parts of the U.N. family to agencies; (3) the need to identify a U.N. Secretariat focal point for conference followup; and (4) sources of new financial support for programs initiated as the result of conference recommendations.

In addressing this subject, the Federal Interagency Committee on Aging early in its considerations identified certain policy imperatives arising out of U.S. policy generally toward the United Nations and its associated agencies: (1) Opposition to the creation of new institutional machinery, either intergovernmental bodies or intersecretariat coordinating mechanisms; (2) opposition to any funding scheme which had the effect of increasing the U.N. regular (i.e., assessed) budget; and, relatedly, (3) adherence to the U.S. position of zero program growth in the U.N. regular budget.

Against this background FICA endorsed the following specific proposals which the United States should pursue in the international preparations for WAA:

(1) *Intergovernmental coordination and oversight.*—The United States should propose that the U.N. Economic and Social Council's (ECOSOC) existing 36-nation Commission on Social Development, which is already responsible for supervising all of the activities of the Center for Social Development and Humanitarian Affairs, be named as the intergovernmental committee responsible for WAA followup. This proposal was agreed to at the third meeting of the WAA 23-nation advisory committee and incorporated in the draft plan of action. (See section on International Preparations.)

(2). *Interagancy coordination.*—The United States should urge that the interagency committee already established to coordinate intersecretariat coordination for WAA to be retained. This proposal was also endorsed in the international preparations and incorporated in the draft plan of action.

(3) *U.N. focal point.*—The United States should support the proposal that the existing U.N. Center for Social Development and Humanitarian Affairs be designated as the U.N. focal point for WAA followup. (The Center carried out or coordinated all of the preparations in the U.N. system for the WAA.) It was also agreed that the United States should propose that the Center's aging programs be strengthened by raising the bureaucratic level within the Centers from the lowest level in the United Nations (a unit) by three levels to a Branch of the Center. While this proposal gained considerable support in the third session of the advisory committee, it encountered strong opposition from Sweden and the U.S.S.R. FICA agreed, however, that the U.S. Delegation should pursue this proposal in the WAA itself. U.S. spokespersons in the advisory committee made clear that any increased costs involved in this proposal would entail reductions elsewhere in the U.N. budget in order to preserve the overriding need for zero program growth.

(4) *Finance.*—The United States should support continuation of the voluntary fund (to which the United States contributed $650,000) established by the General Assembly Resolution 35/129, December 11, 1980, for the WAA. The General Assembly requested the Secretary General, in its subsequent Resolution 36/20, November 9, 1981, "to encourage further interest in the field of aging among developing countries, particularly the least developed among them, within the context of the WAA." The General Assembly's request was incorporation into the draft plan of action with the support of most of the members of the advisory committee, but was opposed,

again, by Sweden and the U.S.S.R. The same split occurred in response to a U.S. proposal that the Center be granted "executing agency" authority by the U.N. Development Program (UNDP) to carry out technical assistance projects for the aging with UNDP funds. FICA agreed that the United States should press for approval of both of these proposals at the WAA itself.

Nongovernmental Organizations (NGO's)

Throughout the U.S. preparations for the WAA, every effort was made to provide for close and continuing consultations with the community of U.S. nongovernmental organizations (NGO's), of which there are over 40, concerned with the aged and problems of aging. An NGO advisory committee to the U.S. coordinator for the WAA was established in the spring of 1981, and met in bimonthly meetings with the coordinator to review the progress of U.S. preparations.

The American corporate and private community was also involved in the U.S. preparation for the WAA, particularly through the active participation of such corporations and organizations as IBM, Travelers Insurance Co., the National Association of Maufacturers, and the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO).

In response to the U.N. Secretary General's request that all countries prepare a national report on aging in order to facilitate information exchange among countries, a major effort was undertaken to produce a comprehensive report on U.S. policy and programs in the field of aging. Through the cooperative efforts of the Departments of Health and Human Services, Commerce, Labor, Education, Housing and Urban Development, and State, and the National Council on Aging (which coordinated the preparation of a chapter on "Nongovernmental Organizations and Foundations," and the private sector (particularly IBM and Travelers Insurance Co., which together coordinated the preparation of a chapter on the "Corporate Sector"), the "U.N. National Report on Aging for the U.S. World Assembly on Aging" was delivered to the WAA Secretary in June 1982. Some 800 copies were made available to other countries.

IV. INTERNATIONAL PREPARATIONS

(A) The WAA Secretariat

William M. Kerrigan of the United States, was appointed Secretary General for the WAA in June 1981. His appointment, at the Assistant Secretary General level, marked the first time in U.N. history that an American was chosen as Secretary General of a major U.N. conference. A retired Foreign Service Officer, Mr. Kerrigan, prior to his U.N. appointment, was the General Secretary of the International Federation on Aging. Mr. Kerrigan took over the direction of a small U.N. Secretariat located in Vienna, established specifically to prepare for the WAA.

(B) The WAA Advisory Committee

To oversee the preparations for the conference and provide for intergovernmental input, the U.N. General Assembly created a 22-nation WAA advisory committee with the following membership: Benin, Byelorussian SSR, Chile, Costa Rica, Dominican Republic, France, Hungary, India, Indonesia, Japan, Lebanon, Malta, Morocco, Nigeria, Philippines, Spain, Suriname, Sweden, Togo, U.S.S.R., United States, and Venezuela.

The advisory committee met in three sessions under the leadership of its chairman, Dr. A. H. B. de Bono of Malta. The first session was held in Vienna, August 17-21, 1981, and approved a plan of organization for the WAA and a draft outline for an international plan of action on aging. The second session took place in New York, February 16-22, 1982, and adopted an agenda and rules of procedure for the WAA. The second session also reviewed the initial draft of the plan of action. The third session again met in Vienna, May 3-7, 1982 and approved a final draft plan of action for submission to the WAA.

(C) Regional Technical Meetings

A major undertaking of the Secretariat was the organization of six regional technical meetings of experts on aging:

—Technical Meeting on Aging of the Middle East and Mediterranean Region, June 3-6, 1980 hosted by Malta.

—Technical Meeting on Aging for the Latin American Region, December 2-5, 1980, hosted by Costa Rica.

- —Technical Meeting on Aging for the Asian and Pacific Region, January 27-30, 1981, hosted by Thailand.
- —Technical Meeting on Aging for the African Region, February 24-27, 1981, hosted by Nigeria.
- —Technical Meeting on Aging for the European Region, June 10-12, 1981, hosted by the Federal Republic of Germany.
- —Technical Meeting on Aging of the North American Region, June 15-19, 1981, hosted by the United States.

The North American Regional Meeting, at the invitation of the WAA Secretariat, was sponsored and coordinated by the National Council on Aging, Inc., and held at the State Department. Participants included representatives from both governmental and nongovernmental organizations and agencies in the United States and Canada.

The Eastern European countries produced a joint report on the "Status and Condition of the Elderly in the Socialist Countries of Eastern Europe," prepared by several gerontological institutes in that region.

The findings and recommendations arising out of the experts' meetings were referred to the U.N. Regional Intergovernmental Commissions and the WAA Secretariat and were considered by them and by the third session of the advisory committee is in putting together the final draft of the plan of action. They were also consolidated into working papers for the WAA itself.

(D) Regional Preparatory Meetings

The technical experts meetings were followed, in most cases, by regional WAA preparatory meetings of governmental representatives. The developing country perspective on the problems of elderly persons emerged from three meetings, convened by the U.N. Regional Commissions for Asia, Latin America, and Africa. (The United States was represented at the Asian and Latin American regional meetings.)

(1) The first such meeting was that of the Economic and Social Commission for Asia and the Pacific (ESCAP) held in Manila October 19-23, 1981. ESCAP produced a plan of action for the region that contained 34 recommendations directed toward national action. The main points surfacing at the ESCAP meeting were the following:

- —80 percent of the population is rural and has no social security coverage and no pension schemes.
- —The family structure in many villages is crumbling because of migration to the cities.
- —The family is the basic resource for the care of the aging and should be strengthened through the provision of external services—by nongovernmental organizations and by the government, where possible.
- —Institutionalization of the aging should be considered as a last resort.

(2) The Economic Commission for Latin America (ECLA) had its preparatory meeting in San Jose, March 8-12, 1982. The draft program of action adopted by the conferees took note of urbanization and the growth of the population over 60 years of age. It stressed the economic problems facing the aging and called for a long-term view of the problems. The plan recommended national action particularly designed to slow rural migration to the cities and the strengthening of the role of the family as the primary social unit. Also recommended was a strengthened role for nongovernmental organizations, older women, and volunteerism.

(3) The third meeting was that of the Economic Commission for Africa in Addis Ababa, March 1-4, 1982. The delegates, while noting potential problems, agreed that today, aging was not among Africa's major problems, since the percentage of persons 60 and over would remain small for the next few decades. However, they noted that this segment of the population was growing rapidly and should be taken into consideration in development planning. A central concern was the deterioration of the traditional extended family and its negative impact on care of the aged. A number of recommendations were aimed at strengthening the family unit and creating useful roles for the aged in it. They stated that segregation of the aged into institutions should be avoided and only used as a last resort. The delegates also stressed the need to find solutions to the problems of aging which would reflect and promote traditional African values.

The fourth and last regional preparatory meeting was that of the Economic Commission for Europe (ECE), which draws its membership from Eastern Europe, Western Europe, and North America, representing, primarily, the developed, industrial country point of view. This meeting was held in Vienna, Austria, April 26-30, 1982. It is in Europe that the "aging of populations" is most significant. The proportions of people 60 years of age and over increased from 12.9 percent in 1950 to 16.7 percent in 1970, and is projected to increase to 19.5 percent by the year 2000. The meeting noted that the aging of populations will slow in the countries already greatly affected (e.g., Austria and Sweden), but there will be a substantial rise in Eastern and Southern Europe. The European and North American countries, as a whole, have extensive programs for social security, geriatric medicine, and social welfare, and this more advanced status was reflected in the ECE regional plan of action. It is interesting to note, however, that developed and developing countries alike emphasized the importance of the family as the basic resource for caring for the elderly and institutionalization as the remedy of last resort.

(E) NGO International Forum on Aging

This forum, held in Vienna, March 29 to April 2, 1982, was attended by 350 persons from 43 countries representing 159 nongovernmental organizations. This was a unique gathering because for the first time in the history of U.N. Global Conferences, NGO's met before the U.N. meeting to develop their own substantive recommendations which were then submitted to the WAA Secretariat for presentation as a formal document to the WAA itself. In the past such NGO sessions have been held during the U.N. world conference itself, sometimes, as in the case of the 1972 Conference on the Human Environment, almost as a competing rather than cooperating endeavor.

V. THE VIENNA WAA CONFERENCE, JULY 26 TO AUGUST 6, 1982

Inaugurated by the President of Austria, the World Assembly on Aging convened in Vienna on July 26. One hundred twenty-one countries and 50 nongovernmental organizations were in attendance. The United States was represented by a delegation of 30 persons, drawn from the administration, Congress, public agencies, nongovernmental organizations, and the private sector, under the leadership of Secretary of Health and Human Services Schweiker. Following a message from the U.N. Secretary General, Javier Perez de Cueller, delivered by the U.N. Director for Development and International Economic Cooperation, the Assembly heard messages from three other world leaders, His Holiness the Pope, and the heads of state or government of the United States, India, and Poland. In his message to the Assembly, read by Secretary Schweiker, President Reagan declared that, "Older persons must have a secure place in society. They must be given the opportunity to contribute both socially and economically. Above all, they must not be denied the dignity that comes from being wanted, needed, and respected."

Following U.N. custom, the head of the host country delegation, Her Excellency Herta Firnberg, the Austrian Minister for Science and Research, was elected President of the Assembly by acclamation. The Assembly also elected three vice presidents for coordination from Hungary, Senegal, and the Philippines, and selected the head of the delegation of Suriname as Rapporteur General. Twenty-one vice chairmen were elected from the United States, Sweden, France, Bulgaria, Romania, U.S.S.R., Algeria, Djibouti, Lesotho, Liberia, Morocco, Tanzania, Indonesia, Japan, China, Kuwait, Sri Lanka, Chile, Dominican Republic, Jamaica, and Venezuela. The chairman of the main committee (Malta) was also elected. These 27 officers made up the general committee of the conference. These posts had been agreed upon at a 2-day preconference meeting held in Vienna July 24 and 25.

(A) Organization of the Assembly

The Assembly decided to carry out its work with a Plenary session and one main committee, meeting simultaneously, and a credentials committee. The general debate consisted of 135 speeches by heads of country delegations, U.N. bodies, and nongovernmental organizations, delivered in Plenary meetings. The substantive work took place mostly in the main committee and consisted of debate and revision of the draft plan of action on aging.

(1) Plenary general debate

The general debate was opened on the first day of the Assembly with an address by William Kerrigan, Secretary General, in which he outlined the principles which had guided preparations for the Assembly. First, the Assembly should have a practical outcome. Second, it should grapple with reality, avoiding abstractions, remembering that the subject dealt with human beings. Third, the subject to be dealt with is basic to common humanity. He emphasized that the problem of aging was common to all countries, developed and developing, and that the economic and social welfare of the whole society in the growing needs of the aging group and the potential resources which old people could offer to society were not taken into account.

In the subsequent country statements, there was near unanimity that the alteration in the "pyramid" of age groups had produced or would produce far-reaching consequences in the economic and social life of all countries, that its effect was already being felt, and that it would continue into the long term. Action would, therefore, be necessary at the national and international levels in order to forestall or palliate any adverse impact of these changes on individuals, communities, and nations.

Most delegations identified the family as the most important resource for providing care for the elderly and considered institutionalization as the solution of last resort. It was recognized by many, however, that traditional family patterns and customs had been greatly affected by industrialization and urbanization with resultant stresses and strains on intergenerational relations. This called for special efforts, not only to insure that the needs of the elderly were recognized and cared for, but that the tremendous potential of the elderly to contribute to the general economic and social welfare was recognized.

There was general agreement that the growing disproportion in the distribution of the sexes among the older generation imposed special problems which should not be neglected. Policies would have to be developed and implemented to provide appropriate services and housing for the larger number of older women, many of whom would be living alone.

The importance of volunteer programs was stressed by many speakers, and countries were urged to make full use of volunteer resources in meeting the problems of older persons.

National systems of retirement, including levels of benefits and age qualifications, were described by nearly all the representatives who took the floor in the general debate. It was recognized that such retirement systems would vary greatly from country to country, reflecting not only demographic trends but also economic and social differences among countries.

Many delegations drew attention to the dearth of information about the phenomenon of aging, its repercussions on national and international economies, and its effects on the political fabric of nations. This indicated the desirability of international cooperation to improve the quality of the data base relating to the elderly and the importance of the exchange of information and experience, and of education, and training in the specialized fields of gerontology and geriatrics. The importance of professionalizing practitioners to provide services to the aging, both within and outside the institutional setting, was also emphasized.

The U.S. general debate statement was delivered on the second day of the Assembly by Secretary of Health and Human Services Schweiker. The Vienna Assembly, he declared, was challenged "to find personal fulfillment for our elderly through new activities and roles that were not as widely available to earlier generations." He cited the tremendous resources represented by the accumulated skills and talents of the elderly and said that no nation could afford to ignore these resources.

Secretary Schweiker reviewed the origin and development of the U.S. social security system and cited the development of related programs, noting that during the current fiscal year, about 27 percent of the entire U.S. Government's budget is devoted to programs benefiting the elderly.

The Secretary reviewed the findings and conclusions of the 1981 White House Conference on Aging, noting that its recommendations parallel many of the recommendations contained in the draft plan of action before the Assembly. He noted that the U.S. administration is committed to eliminating mandatory retirement, believing that this would allow older persons to participate more fully in all aspects of American life. The full text of the Secretary's statement is attached.

(2) Main committee: Draft plan of action

The main committee conducted its deliberations under the chairmanship of Dr. A.H.B. de Bono, who had served throughout the preparations for the WAA as chairman of the 22-nation advisory committee. Three vice chairmen (U.S.S.R., Peru, and Zaire) and a rapporteur (Malaysia) were elected by the main committee at its first session.

The main committee debated the draft plan of action, as it had emerged from the advisory committee and the WAA Secretariat, paragraph by paragraph, over 17 sessions from July 27 through August 5. Although the committee debated over 200 written amendments to the draft, put forward by a wide spectrum of participants, most of the amendments were technical and drafting refinements which improved and strengthened the document and were adopted without too much objection and without a vote.

Only two issues of potentially political contention were raised in the committee and both, after prolonged debate, aided by the work of small drafting groups and adroit corridor diplomacy, were resolved to the mutual satisfaction of all parties. These were Byelorussian and Soviet moves to exploit their disarmament objectives, and the interjection, by Algeria, of the geopolitical ideologies of the North-South inequities controversy.

The disarmament issue was raised at the first meeting of the main committee when Byelorussia proposed to amend the preamble of the draft plan of action by the addition of a lengthy statement calling for a cessation of the arms race and a diversion of funds from military purposes to social uses. After the U.S. delegation privately urged the Soviet delegation to intervene, the Byelorussians withdrew their amendment with the understanding that some reference would be made to disarmament and savings therefrom elsewhere in the document. Ultimately, this issue was amicably resolved by incorporating into a paragraph of the plan, which already contained a mention of disarmament, language already approved by the 35 members of the U.N. Economic Commission for Europe in its regional plan of action. The language as adopted by the committee and subsequently by the Assembly appears in paragraph 20 (a.1) of the plan of action.

The North-South controversy was raised by the Algerian delegation with regard to language in the draft concerning "equitable use of the world's wealth, resources, and technology." The Algerians wanted to expand these words with concepts and ideas reflecting formulations which have proved highly contentious in other U.N. documents and decisions, often forcing the United States and other Western industrial countries into opposition or abstention. The U.S. delegation opposed the Algerian move at the outset on the ground that aging was not a North-South issue and, interestingly, was supported by Pakistan, Argentina, and Mali. When the Algerians persisted and tabled their proposal in writing, the United States rejected it as unacceptable, in any event too complicated to discuss in full committee, and proposed that a small informed group be established to draft compromise language. This proposal was agreed and Algeria, the United States, France, Mali, Pakistan, and the U.S.S.R. were designated to work on the problem. Ultimately, this group produced a draft which was adopted, after extensive debate in full committee, by a vote of 62-0. The text as adopted, by committee and subsequently the Assembly, appears in paragraph 13 of the plan of action.

It is worthy of note that the delegation of the Holy See, which normally has not played an active role in global conferences, was this time active and effective. Among several amendments made, they successfully urged inclusion of the words "spiritual" and "religious" in the section of "Principles." The Holy See also successfully promoted the addition of the following language to the "Principles": "Governments, nongovernmental organizations, and all concerned have a special responsibility to the most vulnerable among the elderly, particularly the poor of whom many are women and from rural areas." They were also responsible for changing "racial discrimination" to "discrimination based on race, sex, or religion" and supported the Italian amendment to add "a respect for human rights" to the paragraph on apartheid (paragraph 20b).

The U.S. delegation submitted 28 written amendments and was successful in securing the adoption of almost every one. The delegation played a key role in including the following additional concepts in the final plan: Personal fulfillment, rural women, spirituality, the role of voluntary groups and NGO's, older women, and reference to private contributions to the trust fund.

The Nordic delegations introduced a series of amendments which would have defeated U.S. efforts to upgrade the U.N. ability to address problems of the aging after the conference was over. The same group proposed, for example, the termination of the trust fund established for the World Assembly on Aging as of August 6, 1982. We opposed this idea and with active support from the French and all the members of the G-77 successfully defeated the Nordic amendments. The Soviets, Canada, and Australia who, in the advisory committee, had supported Sweden in similar moves, did not stand in the way of the U.S. objectives.

After tough negotiations and extensive debate, the committee adopted, without a vote, all of the U.S. initiatives, calling for:

—ECOSOC's Commission for Social Development to be the intergovernmental body responsible for reviewing the implementation of the plan of action.

—The Administrative Committee on Coordination (ACC) to provide continuing liaison and coordination within the U.N. system of agencies for implementing the plan.

—The designation of the U.N. Center for Social Development and Human Affairs (CSDHA) in Vienna as the focal point for followup activities for the WAA and "the strengthening" of the Center "within the existing global resources of the United Nations." The Secretary General of the United Nations was asked "to give due consideration to the provisions of appropriate increased resources for implementation of the plan of action."

—The continuation of the WAA voluntary trust fund, to which voluntary public and private contributions should be encouraged.

The U.S. delegation, in the spirit of compromise, withdrew two potentially controversial proposals, one which would give CSDHA executing-agency status with UNDP, and the other for a study of the impact of removing retirement age limitations for U.N. staff. The U.S. delegation did, however, note the U.S. intention to pursue these initiatives in other U.N. fora.

In its final session the evening of August 5, after agreeing to minor editorial changes and accepting an additional noncontroversial amendment on consumer protection, the main committee agreed unanimously to recommend the draft plan of action to the Assembly for adoption. The final draft contained 62 recommendations, most directed to governments, covering the areas of health and nutrition, housing and environment, the family, social welfare, income security and employment, and education.

(3) Credentials Committee

The work of the Credentials Committee was dispatched in a single meeting on July 24, when the credentials of 121 delegations were approved without votes. Politically motivated attacks on the credentials of particular delegations were moderate and confined to the delegations of Chile and Kampuchea. There were no references to the credentials of the Israeli delegation.

(4) Final plenary action

The World Assembly on Aging opened its final session on August 6, with an address by U.N. Secretary General Javier Perez de Cuellar. Noting that for the first time the majority of the population is destined to reach old age, the Secretary General cited the holding of the Assembly as an example of the foresight of the international community: It had laid the basis for the dealing with the issue of aging in its early stages in order to be prepared for the future. He said he would urge the General Assembly to be responsive to the plan of action and to insure its implementation through appropriate action.

The report of the main committee, including the Plan of Action on Aging, was then adopted by acclamation. Remarkably, and for the first time in the history of U.N. single-topic conferences, there were no written or oral reservations to the plan of action nor any substantive explanations of vote.

Nine resolutions were introduced in the plenary dealing with the following subjects: Aging People in Lebanon (Algeria); Day for the Aging (Japan); Practical Training Centers (Malta); Clearing-House on Aging (France); United Nations Fund for Population Activities (UNFPA) and Aging (Chile); Elderly Consumers (Senegal); International Cooperation (Chile); WAA Trust Fund (Chile); and Strengthening the Center for Social Development and Humanitarian Affairs (Chile). Except for the resolutions on Lebanon (adopted by an earlier plenary and discussed below) and elderly consumers, all the remaining resolutions either duplicated or were closely related to recommendations contained in the plan of action. The U.S. delegation brought this point to the attention of the Assembly's general committee and a successful effort was undertaken, with the committee's concurrence, to convince the sponsors to withdraw all the resolutions except those on the Lebanese issue and consumer protection. As the result of a last minute compromise, a revised text of the consumer protection resolution was added to the plan of action and that resolution was also withdrawn. As a result, the plan of action stands on its own merits, uncluttered by associated resolutions which would have the effect of suggesting that the Assembly believed certain aspects of the plan should receive special attention while in fact such resolutions only reflect the parochial interests of their sponsors.

(5) Political atmosphere at the WAA

The current Israel-Lebanon crisis pervaded the plenary speeches and was the only political issue to confront the Assembly in the form of a resolution. This resolution, launched by Algeria and cosponsored initially by 16, mostly Arab States, later picked up 15 additional sponsors from among the group of 77 countries. The resolution came to a vote at the Assembly's 15th Plenary meeting on August 5. Before the vote, the Israeli delegate spoke at great length in opposition, engendering a strong vocal response from the floor and incurring four censures from the Assembly President for remarks not germane to the resolutions. Relatively moderate in comparison with other U.N. resolutions dealing with Arab-Israeli issues, the Algerian resolution was nevertheless selectively one-sided and dealt with political issues falling outside the mandate of the Assembly. At the request of the U.S. delegation, the resolution was put to a vote and adopted by a vote of 73 to 2 (United States and Israel) with 26 abstentions. Nineteen delegations were absent when the vote was taken. WEOG votes in favor of the resolution were Japan, Greece, Malta, and Austria. The U.S. statement in explanation of its vote is attached.

The PLO did not attend the WAA although under pertinent UNGA rules it had the right to attend as an observer.

Aside from the Algerian resolution, political issues at the Assembly were remarkably muted. Plenary statements on the Israel-Lebanon crisis were, for the most part, mile and in the context of the Assembly's concern for the problems of elderly persons. The only political attack on the United States was made by Iran in its general debate statement. The U.S. delegation chose not to exercise its right of reply to what has become a familar Iranian refrain.

North-South issues were not an important issue at the Assembly. The only exception was the Algerian proposal raised with regard to the plan of action and that point was resolved to the mutual satisfaction of all delegations.

(6) Western Europe and other groups

The WEOG met three times during the Assembly under the competent chairmanship of Canadian Ambassador Capithorne. Although there was no consensus in the group on the Lebanon resolution or on various aspects of followup to the plan of action, the WEOG provided an excellent forum for dialog, and worked effectively to convince the sponsors of resolutions that duplicated recommendations in the plan of action to withdraw them. The Vienna WEOG achieved a nice balance between the extremes of the formal group B spokesperson approach used for UNCTAD and UNIDO meetings and the narrow election of States approach found in New York.

(7) Conference officers

Dr. Herta Firnberg, Austrian Minister for Science and Research, was elected President of the Assembly. Despite early indications that she would be less than effective in this role, she, in fact, performed competently. She responded to suggestions from the U.S. delegation for behind-the-scenes maneuvering, which was helpful in heading off potential difficulties on several occasions. As chairman of the main committee, Dr. A. H. B. deBono of Malta performed magnificiently in a very difficult assignment. When it became apparent at the midpoint of the second week that the Secretariat had issued a plan of action replete with errors, deBono's patience was stretched to the breaking point and, confronted with suggestions that he was responsible, announced his resignation in a hastily called press conference. WAA SYG Kerrigan and a member of the U.S. delegation then met with deBono for a 1½-hour stroking session, and he agreed to resume the chair for the final meeting of the main committee at which the plan of action was approved.

(8) Press

Press coverage during the U.N. World Assembly on Aging consisted primarily of in-depth interviews in the local Vienna dailies: e.g., the Socialist Party daily Arbeiter Zeitung featured interviews with Assembly President Dr. Firnberg and with the Gray Panthers' spokeswoman Lydia Bregger. The U.S. delegation, in cooperation with the International Council of Jewish Women, sponsored two very successful screenings of the Academy award-winning film on intergenerational linkages, "Close Harmony." The film was later shown by the ICA press officer to the U.S. Embassy staff. Surgeon General Koop was interviewed about the WAA by Austrian television and arranged to assist the AMA Journal with a story on the Assembly. Ambassador McDonald was interviewed by Time magazine and the New York Times. He also spoke to the Austrian organized NGO seminar on aging on July 31.

(9) Relations with other delegations

A spirit of cooperation pervaded the Assembly, and relations among delegations were generally excellent. As noted earlier, consensus in the WEOG was generally lacking, as particular delegations, especially the French, Japanese, Netherlands, Swedish, and United States, had specific objectives. Austria, as host country, had a lot at stake in the success of the conference, and was nervous throughout. Among the G-77, Algeria, Chile, Senegal, Pakistan, and Brazil were most active and, with the exception of Algeria, constructive. The PRC played almost no role at all. For the most part, delegations were composed of substantive experts in the field of aging, which contributed to the lack of polemics. Several delegations were larger than the United States, including Canada (29), France (29), Austria (38), and Spain (36).

(10) NGO relations

Although there was some concern among NGO's at the beginning of the WAA about their role in the Assembly, the concern, at least among American NGO's, was alleviated by assurances from the U.S. delegation that their views would be considered and they would be kept apprised on a regular basis of developments within the Assembly. In fact, most NGO's had been contacted before their departure from the United States, inviting them to meet as a group and submit recommendations and comments.

More than 30 U.S. NGO's met at three separate briefings with members of the U.S. delegation during the course of the Assembly. The United States was the only country to meet regularly with its NGO's. The U.S. delegation expressed a willingness to consider amendments to the plan of action proposed by the NGO's, and a number of these, after lengthy dialog within the U.S. delegation, were proposed by the United States and adopted by the main committee. These included language emphasizing the role of NGO's in implementing the international plan of action, amendments calling for action against crime against the elderly, and efforts to diminish negative stereotyping among employers regarding older worker productivity. NGO's were also encouraged to make contact with other delegations to secure the adoption of their proposed amendments.

Overall, the American NGO's expressed satisfaction with and appreciation for their treatment by the U.S. delegation. The delegation shared with them the American positions on political issues and, where appropriate and permissible, its strategies in securing adoption of U.S. recommendations. This produced a strong feeling of participation by them in the American effort.

(11) Secretary Schweiker's participation

As head of the delegation, HHS Secretary Schweiker read a message to the Assembly from President Reagan at the opening session and delivered the U.S. statement during the general debate. The Secretary hosted a luncheon for heads of delegation and U.N. officials at the Palais Pallavicini and represented the delegation at various representational events. He gave interviews to U.N. Radio, VOA, and Time magazine. He also met with Austrian Minister of Social Affairs Dallinger, met with American Embassy officers to discuss the U.S. domestic scene and United States-Western Europe relations, was guest of honor at the United States-Austria bilateral lunch hosted by Charge Polansky, and visited Sos Kinderdorf Village, where parentless children live in a family setting.

(12) U.S. delegation

The U.S. delegation (30 strong), which was made up of a diverse group of individuals representing the administration, Congress, public agencies, NGO's, and the private sector, performed extremely well as a functioning team. The group understood that a unified position was necessary and all worked diligently to put forth a positive presentation of U.S. policies and programs regarding the elderly. The congressional members of the delegation and their staff were especially helpful, and effectively demonstrated to other delegations the role and interest of the legislative branch in aging issues. The support staff, made up of Judy Howe (NIA), Ed Marcus (HHS), and Suzy Wochos (OIC), together with Marge Philbert, Dorothy Farley, and our temporary secretaries, made a tremendous contribution to the success of the conference.

(13) U.S. representation functions

The delegation was involved in three U.S. representational events which contributed greatly to morale and the development of a team spirit. On the Sunday evening before the opening of the WAA, Ambassador and Mrs. Kirk hosted a buffet supper at their home. This event was important in developing a friendly and cooperative spirit among the delegation members. Secretary Schweiker hosted a luncheon for heads of delegation at the Palais Pallavicini on July 27. The presence of a number of U.S. delegation members clearly contributed to the luncheon's success. Finally, the U.S. delegation hosted a reception for other delegations and U.S. NGO representatives on the evening of August 2 at the residence of the U.S. Ambassador to Austria. Some 350 persons attended and, by all accounts, this event was a great success and the social highlight of the conference.

(14) Why was the conference a success?

It might be useful to briefly review the reasons for the outstanding success of the WAA. The following points certainly were important to that success:

(1) There was careful advance preparation by the U.N. Secretariat. Fourteen preconference meetings, both at the expert and at the intergovernmental level, were held in various parts of the world before the actual convening of the World Assembly. This sets a record and also provided governments with a great deal of background information for the Assembly.

(2) The U.N. Secretariat staff put together, after great effort, a very solid draft plan of action for governments to work on.

(3) U.N. Secretary General William Kerrigan (United States) played an important leadership role in stimulating governmental and nongovernmental interest in the conference before the meeting took place.

(4) The Maltese chairman of the 22-nation preparatory committee, who was elected chairman of the main committee of the World Assembly on Aging, played an instrumental role in keeping delegates on track and demonstrated for all to see the key role a chairman can play. His controversial election was well worth our strong support.

(5) Preparations by the United States were also extensive and important to the success of the conference:

(A) A Federal interagency committee was set up 16 months before the WAA and included (a first) staff members from both the House and Senate Committees on Aging.

(B) An NGO advisory committee was established 16 months before the WAA and was actively involved in preparations for the conference.

(C) An outstanding U.S. national report, the best of some 50 national reports prepared by other countries, demonstrated U.S. leadership and interest.

(D) The U.S. position on conference followup was spelled out 6 months before the conference and made known to all countries attending the conference through telegrams to our embassies.

(E) The United States contributed $650,000 to a WAA trust fund for technical assistance to developing countries, making it the largest contributor to the fund.

(F) The fact that Secretary Schweiker agreed, 6 months before the conference started, to head the U.S. delegation, telegraphed the importance the United States gave to this conference.

(G) The President's message to the conference, as one of three heads of state addressing the meeting, again indicated the importance to the United States.

(H) The U.S. delegation was competent and dedicated, and brilliantly supported by knowledgeable, hard-working staffers.

(6) The Western European and Others Group were organized, experienced, and worked well together.

All of these factors came together in a favorable way so that the plan of action could be adopted by acclamation, without reservation by any government.

MEMBERS OF U.S. DELEGATION

REPRESENTATIVE

The Honorable Richard S. Schweiker, Secretary of Health and Human Services.

ALTERNATE REPRESENTATIVES

The Honorable Dorcas R. Hardy, Assistant Secretary for Human Development Services, Department of Health and Human Services.

The Honorable Virginia Knauer, Special Assistant to the President, The White House.

The Honorable C. Everett Koop, M.D., Surgeon General of the United States, Department of Health and Human Services.

The Honorable John W. McDonald, Jr., Ambassador, Coordinator for World Assembly on Aging, Department of State.

The Honorable Lennie-Marie Tolliver, M.D., U.S. Commissioner on Aging, Department of Health and Human Services.

SENIOR ADVISERS

The Honorable Adelaide Attard, Chairman, Federal Council on the Aging, Department of Health and Human Services.

The Honorable Roger Kirk, Ambassador, U.S. Permanent Representative to UNIDO.

CONGRESSIONAL ADVISERS

The Honorable Mario Biaggi, U.S. House of Representatives.
The Honorable Robert K. Dornan, U.S. House of Representatives.
The Honorable Claude Pepper, U.S. House of Representatives.

CONGRESSIONAL STAFF ADVISERS

Robert B. Blancato, Select Committee on Aging, U.S. House of Representatives.
Charles Edwards, staff director, Select Committee on Aging, U.S. House of Representatives.
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David Hohman, Office of International Affairs, Department of Health and Human Services.
Ellen Sehgal, Office of Research and Development, Department of Labor.

PRIVATE SECTOR ADVISERS

Constance Armitage, Chairman, 1981 White House Conference on Aging, Inam, S.C.
Morrison H. Beach, West Hartford, Conn.
Cyril F. Brickfield, executive director, American Association of Retired Persons, Washington, D.C.
Eleanor Cain, National Association of State Units on Aging, Washington, D.C.
Curt Clinkscales, National Alliance of Senior Citizens, Falls Church, Va.
George Telisman, president, National Association of Area Agencies on Aging, Washington, D.C.

U.S. SCOPE PAPER

OVERVIEW

The World Assembly on Aging offers the world a unique opportunity. This is the first time in history that governments will gather together to discuss the aging of society and the enormous impact this process is having and will continue to have on the social, economic, and political fabric of all countries in both the developed and the developing world.

There are 300 million people over 60 in the world today, and this number will increase to about 600 million by the year 2000. This unprecedented situation will place increasing demands on governments and societies for economic and social policies to deal with this new reality. Many of the questions concerning how to cope with a much larger population have already been asked, but the answers and solutions are far from clear. The function of the WAA will be to bring these issues into sharp focus for the world's policymakers, to explore solutions and to stimulate the development of meaningful policies at the national level. This will not be as easy as it may appear. The mere fact that the more critical problems remain in the future, in the developing world, make if difficult to attract their attention. Governments always have more pressing problems at hand, and they almost always have difficulty in addressing a future issue, even when it may be only a few years away. A key measure of the WAA's success, therefore, will be whether the message can be gotten across: The number of aged is clearly increasing, and we must start thinking about it—not tomorrow—but now.

The purpose of this paper is to highlight the essential elements of the WAA. Detailed discussions of particular questions will be found in individual position papers.

HISTORY OF THE WAA

The original impetus for this conference was provided in 1977 by resolutions of the Senate and the House of Representatives calling for the convening of the WAA.

The proposal was conveyed to the United Nation and in 1977, the U.N. General Assembly invited member States to submit their views on the holding of such a conference. In 1978, the United States, with strong support from Malta, was successful in having the UNGA adopt a resolution to hold the WAA in 1982. In 1980, the UNGA adopted a program for the WAA which described its purposes as the following:

—To focus the attention of governments on the various issues of aging in designing policies and programs for economic and social development in both developed and developing countries.

—To provide an international forum for an exchange of views among governments on the ways and means of dealing with issues of the aging, including the machinery required for administrative and legislative actions.

—To identify aspects of various issues and consider methods to meet the need for action at the national, regional, and international level and to consider, in particular, how countries can, through increased international cooperation, derive benefit from the knowledge and experience already acquired regarding the various issues of the aging; and

—To focus attention on, and encourage wider participation in, and support for, present and future activities and programs of U.N. organizations and other international organizations related to aging, and to give them guidelines and directions.

The General Assembly established a 23-nation advisory committee to make preparations for the WAA. The committee's work is discussed below under "Preparations for the WAA."

The WAA is one of a series of 15 single-topic U.N. global conferences that have been held since 1972. The first was on the human environment (Stockholm), and others have been held on such subjects as population, food, women and development, water, employment, and new and renewable sources of energy. The basic objective of such meetings is to focus the world's attention on a given subject and try to stimulate political action at the national level on that issue.

The United States has been a firm supporter of the WAA since its inception, and the U.S. Government has pledged $650,000 to the WAA voluntary fund. As a result of vigorous lobbying by the State Department, William Kerrigan, an American, is serving as Secretary General of the WAA. This is the first time in U.N. history that an American has been Secretary General of a major U.N. conference.

PREPARATIONS FOR THE WAA

The United Nations has held three meetings of the 23-nation WAA Advisory Committee, of which the United States is a member, in order to plan for the WAA. Actual preparations for the WAA are managed by a part of the U.N. Secretariat, directed by Secretary General William Kerrigan and located in the U.N. Centre for Social Development and Humanitarian Affairs in Vienna, Austria.

The first meeting of the advisory committee took place in Vienna, August 17-21, 1981, and approved a plan of organization for the WAA as well as a draft outline for an international plan of action on aging.

The second meeting was in New York, February 16-22, 1982, and adopted an agenda and rules of procedure for the WAA. At that meeting it was decided not to adopt a separate Declaration on the Rights of the Aging. It also reviewed and amended the text of the draft plan of action which the U.N. Secretariat had drafted.

The third meeting of the advisory committee met in Vienna from May 3-7, 1982, and again reviewed the draft international plan of action and approved its submission to the WAA. After approval by the WAA, the plan will be submitted to the U.N. General Assembly in October 1982, for final approval.

The WAA Secretariat organized six regional technical meetings of experts on aging in preparation for the WAA, including one for North America which was held in Washington, D.C., in June 1981. The six technical reports were then reviewed by governments at a series of meetings sponsored by the five U.N. Regional Economic Commissions. The recommendations of governments arising out of these regional meetings were referred to the WAA Secretariat and were considered by them and the third meeting of the advisory committee in putting together the final draft of the plan of action for the WAA. These regional recommendations are found in the briefing book for the U.S. delegation.

In addition to the work of the United Nations itself, several of the major specialized agencies in the U.N. system have played key roles in stimulating thinking and action concerning the problems and potential of the aging. The World Health Organization (WHO) and the International Labor Organization (ILO) have been leaders in this area, while the Food and Agricultural Organization (FAO), the U.N. Development Program (UNDP), and the U.N. Educational, Scientific, and Cultural Organization (UNESCO) have played important roles in planning for the world conference.

The United States has also gone through a lengthy preparatory process. In early 1981, a Federal Interagency Committee on Aging was established which includes membership from the Congress and has met regularly to discuss and approve each stage of U.S. participation in the WAA. A secretariat was set up in the Department of State to coordinate U.S. preparations for the WAA. The secretariat also edited and published the U.S. National Report on Aging, which is the official U.S. submission to the WAA.

THE NGO ROLE

In the non-Communist, developed world the nongovernmental organizations (NGO's play a key role in developing national and local programs for the aging. They are organized, highly motivated, and frequently well funded. The NGO's are also playing a significant role on the international level. An NGO Committee on Aging was organized in New York in 1977, and meets regularly. The committee maintains close contact with the U.N. Secretariat as well as with other NGO groups. There is also an NGO Committee on Aging in Vienna which meets regularly and maintains liaison with the U.N. Centre for Social Development and Humanitarian Affairs. The New York and Vienna committees work in close cooperation with one another.

An NGO Forum on Aging was held in Vienna March 29 to April 2, 1982, and some 350 people from 43 countries representing 159 organizations participated. This was a unique gathering. For the first time in the history of these global conferences, NGO's gathered before the U.N. meeting to develop their own substantive action plan which was then submitted to the U.N. Secretariat and will be presented to the WAA itself as a formal NGO document. In addition, there will be a number of NGO's at the WAA itself as official observers and unofficial lobbyists.

In the United States the NGO's are particularly important. There are approximately 40 national organizations for the aging throughout the country, and their total membership is about 18 million. The American Association of Retired Persons alone has 13.5 million members and the National Council of Senior Citizens has 4 million. They have a dedicated and vigorous membership, and they constitute a real political force that the Congress and the administration bear in mind when formulating policies and programs.

The American corporate community is also actively involved in the concerns of the aging. A number of orgnizations such as IBM, Travelers Insurance Co., the National Association of Manufacturers, and the AFL-CIO have participated in preparations for the WAA.

U.S. preparations for the WAA have been made in close consultation with the NGO community. An NGO advisory committee to the U.S. coordinator for the WAA was established and has met about every 2 months since January 1981, with the coordinator. This committee, chaired by the president of the National Council on Aging, also convened with Canada and the U.N. Secretariat at the North American Technical Meeting on Aging at the State Department in June 1981, in preparation for the WAA.

THE DEMOGRAPHIC QUESTION

The basic force behind the convening of the WAA is the realization that the aged (persons 60 years or over) represent the most rapidly growing sector of the world's population. This is an entirely new phenomenon in the world, and it raises a number of economic and social questions which are addressed in this paper.

The statistics involved may be looked at in two principal ways. The first is that of absolute numbers. According to U.N. estimates, the world's total population will increase from about 4.1 billion in 1975, to 6.1 billion in the year 2000, an increase of 49 percent. The world's total aged population, according to the United Nations, is expected to advance from 1975's 348 million to 590 million in 2000. That represents an increase of 70 percent.

A breakdown between developed countries (CD's) and less developed countries (LDC's) presents a different picture. In the DC's the United Nations projects population as a whole to increase from 1,131 million in 1975 to 1,312 million in 2000, or 16 percent. The aged in the DC's would increase from 166 million to 230 million during the same period, an increase of 39 percent. In the LDC's the change is expected to be even more pronounced: Total LDC population is estimated by the United Nations to increase from 2,959 million in 1975 to 4,823 million in 2000, a 63-percent increase. The aged, on the other hand, are expected to increase 100 percent from 180 million to 360 million. Thus, by the year 2000, the world will have experienced a tremendous increase in the number of aged persons, and the percentage increase will be particularly high in the LDC's.

The second way of perceiving this phenomenon is to consider the aged as a percentage of total population. In 1975, the world's 346 million aged persons constituted 8.5 percent of the total population. By 2000, using the same U.N. statistics, they will constitute 9.6 percent of the population, an increase of 1.1 percentage points. The difference between the DC's and the LDC's in terms of the aged as a percent of population is striking. In the DC's in 1975, older persons comprised 14.7 percent of total population, but by 2000 that percentage is expected to leap to 17.5 percent. In the LDC's the comparable statistics for the same period are less dramatic: From 6.1 percent to 7.5 percent. The following table summarizes these findings:

POPULATION

[In millions]

	1975	2000
World:		
Total population	4,090	6,135
Aged population	346	590
Aged as percent of total population	8.5	9.6
Developed countries:		
Total population	1,131	1,312
Aged population	166	230
Aged as percent of total population	14.7	17.5
Less developed countries:		
Total population	2,959	4,823
Aged population	180	360
Aged as percent of total population	6.1	7.5

Thus, it would appear that by the year 2000 almost two-thirds of the world's aged will reside in the LDC's. However, the concentration of the aged as a percentage of population will be far greater in the DC's (17.5 percent versus 7.5 percent in the LDC's.

SOCIOECONOMIC QUESTIONS

The projection of 590 million persons aged 60 or over by the end of this century implies social, economic, and political demands on society of immense proportions. One of the objectives of the WAA is to identify those demands and problems and to start the process of developing national policies to address them. An illustrative, but not exhaustive, list of issues for the WAA to consider is the following:

—Full integration of the elderly into the social and economic life of the country.
—The impact of aging on social and economic development, particularly in the LDC's.
—Health care.
—Housing and environment.
—Strengthening and supporting the role of the family.
—Social welfare.
—Income maintenance and employment.
—Education.
—Problems of special population groups such as the rural aged, older women, the disabled, and minority aged; and
—Data collection and research.

The U.N.'s draft plan of action sets forth a number of recommendations for national action and these will be specifically addressed in individual position papers. It is clear that meaningful action plans for the aged must be developed by individual governments in response to national needs. The U.N. role is to stimulate such planning. Recommendations arising out of the WAA are, of course, just that and are not binding in nature.

One other dimension of the socioeconomic problems of the aging in the year 2000 should be borne in mind. Present U.N. projections appear to assume that, apart from decreases in both fertility and mortality, all other factors will remain relatively the same. But they may not. There have been a number of serious studies that project discrepancies between the demands of an ever-increasing human population and the ability of the Earth's finite resources to satisfy those demands. There may be shortfalls in supplies of agricultural, fishery and forest products, water for human consumption, and energy and nonfuel minerals. Urban expansion and increased pollution levels will complicate the situation. These difficulties will not be unique to the aged, but will affect all mankind. The point, however, is that the world in the year 2000 will be struggling with a much larger total population competing for resources, and dealing with the problems of the aged may prove to be immensely more difficult than dealing with identical problems in 1982.

DEVELOPMENT AND THE LDC'S

The LDC's embrace economic development as a primary goal. Such development tends to produce social changes that are not always anticipated by the countries involved. As the overall development of a country progresses and as there are improvements in such things as nutrition and health care, there will tend to be a decrease in mortality, particularly infant mortality. There may also be a decrease in fertility. The net effect of these changes will be an increase in the number of young people who will live longer lives, and this in turn is eventually translated into a greater number of elderly in the society.

Economic development means change. Rapid economic change can cause social upheavals that drastically alter traditional values as well as the role in society of the aged. When this social change occurs at the same time that the number and proportion of the aged is increasing, the problems of the aging are exacerbated.

As noted in the demographic section of this paper, the aged population in the less developed countries is expected to double between 1975 and the year 2000. Many LDC's already face funamental problems today in coping with the demands of their populations. This doubling of the older population will put immense strains on many governments, particularly those who are called the least developed among the LDC's.

Persuading many LDC's that the problems of aging are just over the horizon is not easily done. Their present staggering problems command their immediate attention. Typically, these countries have very youthful populations. Thus, there is an understandable preoccupation with such issues as youth unemployment and general economic expansion. The year 2000 seems very remote.

Many local government officials from the Third World state that traditional institutions, primarily the family, have provided and will continue to provide for the aged in their country. However, in view of the worldwide phenomenon of increasing urbanization, a massive move from the village to the city, their faith in traditional solutions may not be well-founded. In other words, as societies are disclosed by rural emigration and forces of modernization and industrialization, traditional institutions face increasing pressures in fulfilling these responsibilities. One cannot generalize, and the questions must be examined culture by culture and country by country. it is nevertheless evident, however, that the problem is rapidly getting out of hand.

Growing awareness of the problems of aging has been evidenced by the LDC's in three WAA preparatory meetings held by U.N. Regional Economic Commissions in Asia, Africa, and Latin America.

(I) The first such meeting was that of the Economic and Social Commission for Asia and the Pacific (ESCAP) held in Manila, October 19-23, 1981. ESCAP produced a plan of action for the region that contained 34 recommendations directed toward national action. The main points of view that surfaced at the ESCAP meeting were the following:

(1) 80 percent of the population is rural and has no social security coverage and no pension schemes.

(2) The family structure in many villages is crumbling because of migration to the cities.

(3) Institutionalization of the aging should be considered as a last resort.

(4) The family is the basic resource for the care of the aging and should be strengthened through the provision of external services—by nongovernmental organizations and by the government, where possible.

(II) The Economic Commission for Latin America (ECLA) had its preparatory meeting in San Jose, March 8-12, 1982. The draft program of action adopted by the conferees took note of urbanization and the growth of the population over 60 years of age. It stressed the economic problems facing the aging and called for a long-term view of the problems. The plan recommended national action, particularly rural assistance to slow migration and the strengthening of the role of the family as the primary social unit. Also recommended was a strengthened role for nongovernmental organizations, older woman, and volunteerism.

(III) The third meeting was that of the Economic Commission for Africa in Addis Ababa, March 1-4, 1982. The delegates, while noting potential problems, agreed that aging was not among Africa's major problems, since the percentage of persons 60 and over would remain small for the next few decades. However, they noted that this segment of the population was growing rapidly and should be taken into consideration in development planning. A central concern was the deterioration of the traditional extended family and its negative impact on care of the aged. A number of recommendations were aimed at strengthening the family unit and creating useful roles for the aged in it. They stated that segregation of the aged into institutions should be avoided and only used as a last resort. The delegates also stressed the need to find solutions to the problems of aging which would reflect and promote traditional African values.

DEVELOPED COUNTRY PERSPECTIVES

In December 1981, the Department of State asked all of its Embassies abroad to report on preparations by the host governments for the WAA. As might be expected, the developed countries of the world were well aware of the WAA and were planning to attend. Part of the reason for this positive attitude is that those countries already have large aged populations and have already had to come to grips with the issues of aging. These countries provide a wide range of social services such as health care, housing, income support, etc., for increasing numbers of elderly persons.

In 1980, about 15 percent of the U.S. population was age 60 or over, and in Canada the proportion was about 13 percent. Both the United States and Canada have addressed problems of income security, employment, the family, housing, environment, health, social welfare, education, recreation, leisure, and cultural activities for the aging. These questions were reviewed by the Technical Meeting on Aging of the North American Region in Washington, D.C., June 15-19, 1981.

The Economic Commission for Europe, whose members are from Eastern Europe, Western Europe, and North America, held their preparatory meeting in Vienna, April 26-30, 1982. It is in Europe that the "aging of populations" is most significant. The proportion of people 60 years of age and over increased from 12.9 percent in 1950 to 16.7 percent in 1970, and is projected to increase to 19.5 percent by the year 2000. The meeting noted that the aging of populations will slow in the countries already greatly affected (e.g., Austria and Sweden), but there will be a substantial rise in Eastern and Southern Europe. The European countries as a whole have advanced programs for social security, geriatric medicine, and social welfare. The experience of these countries in dealing with aging populations will make a valuable contribution to the WAA.

POLITICAL ISSUES

It is an unfortunate fact of modern conference diplomacy that, regardless of how innocuous the subject matter of a conference may be, some delegations will introduce extraneous political issues. The U.S. position in general is that conference time should not be wasted on irrelevant political questions and that discussion should be confined to the subject matter of the meeting. Examples of political questions that could arise at the WAA are the following:

—Credentials: Some delegations may challenge the credentials of such nations as Israel or South Africa. The United States opposes such harassment.

—Arab-Israeli Issues: Third-World nations, particularly the Arabs, may attempt to use the WAA as a forum for the condemnation of the Camp David Accords, Israeli annexation of the Golan Heights, Israeli attacks on Lebanon, Israeli practices in the occupied territories, etc. We oppose such moves.

—Namibia/South Africa: African delegations may try to open debate on South Africa's continued occupation of Namibia as well as the apartheid issue. These are not appropriate topics for the WAA.

—U.S. territories/Puerto Rico: The United States is often portrayed as a colonial power in the Pacific Islands and Puerto Rico. The United States is committed to political status negotiations in the Pacific. Puerto Rico is self-governing and has a continuing right to determine its political status.

—El Salvador: An attempt may be made to depict our relations with El Salvador as interventionist and oppressive. Our aim in El Salvador is to assist that country in achieving a stable, democratically elected government.

—Massive transfer of resources from North to South: This proposal is frequently raised by LDC's as a solution to their economic problems. This question is not appropriate in the WAA context, inasmuch as it is already being addressed in U.N. fora as a principal topic of the proposed global negotiations.

The foregoing is intended to be an illustrative, not exhaustive, list of possible political issues. Other questions could be introduced. Specific guidance on these and other issues is provided elsewhere in the briefing material.

U.S. OBJECTIVES

The U.S. Government has long been concerned with both the opportunities and problems posed by an older population. As the initiate of the World Assembly on Aging, we want to see the WAA succeed in achieving its stated objectives and particularly its general goals of educating national planners and raising the level of concern over the problems of the aged.

Within this context of seeking to insure the WAA's success, we have a number of general objectives at the conference:

(1) We should stress the national approach to problems of the aging. That is while this U.N. forum will serve as an essential catalyst, action programs and policies to reach the aged must be implemented by the member governments at the national and local levels.

(2) We should encourage nations to focus on problems now and not postpone consideration of these issues on the mistaken assumption that they are too far in the future.

(3) It is important to impress upon the LDC delegations that, contrary to their assumption that aging is a developed country phenomenon, their problems may be even more pressing than our own.

(4) We should stress that the aged are a valuable social and economic resource, and not necessarily a burden to society. They represent an immense pool of talent that can be tapped for the benefit of society as a whole.

(5) We should also urge others to find realistic ways to enhance the positive and diminish the negative consequences of changing age structures.

(6) We should stress that the aging should participate in the planning and implementation of programs directed toward them. In order to develop realistic and responsive programs for the aging, the elderly's own needs, interests, and preferences must be taken into account.

(7) We should emphasize that the goal is to maintain an age-integrated society, one in which, for all age groups, age discrimination and involuntary age segregation are eliminated, and mutual supports between generations are strengthened.

(8) We believe that older persons should, to the extent possible, retain their independence in their communities and remain in their own homes.

(9) We agree that the family should remain the primary source of care and concern for the aging.

(10) We should urge that language on personal fulfillment be incorporated in the plan of action.

(11) Institutionalization of the aging should be the solution of last resort. (In the United States today, only 1 out of 20, or 5 percent of our aging population, is institutionalized.)

(12) We should encourage more gerontological and geriatric training and education for professionals working with the aged and seek to recruit more people for this work.

(13) More attention must be devoted to older women, intergenerational linkages, employment programs for the aging, and volunteerism.

(14) Finally, NGO's which represent or serve the aging are uniquely equipped to develop and manage programs for the aging and are important channels for the direct expression of older persons' needs and interests. They should be encouraged to continue and expand their activities.

U.S. GOALS AND INITIATIVES

In addition to these general objectives, the United States has certain specific goals at the WAA and will put forward certain initiatives to achieve these goals.

For any global U.N. conference to be considered a success, there are four, nonsubstantive issues which have to be addressed and resolved to the general satisfaction of all participants. They are:

(1) The question of an intergovernmental mechanism which has the authority to oversee the implementation of the conference recommendations in the postconference period.

(2) The matter of intersecretariat and interagency coordination among various parts of the U.N. family of agencies in the postconference period to insure there is no overlap or duplication of functions.

(3) The question of a U.N. Secretariat focal point for conference followup, whether it be a new U.N. agency or an existing U.N. mechanism.

(4) The issue of financial support for the plan of action, i.e., is a new fund necessary, or can existing facilities and financing be used?

The United States put forward specific ideas with regard to these four issues at the second and third meetings of the advisory committee. We made excellent progress but some problems remain. There will be considerable discussions of these issues, both formally and informally, at the WAA.

The following is a status report as we move into the WAA:

(1) *Intergovernmental coordination.*—At the second meeting of the advisory committee, there was an informal proposal put forward calling for the advisory committee to be converted into a permanent intergovernmental committee on aging to follow up on the recommendations of the WAA. The U.S. delegation strongly opposed this move and the plan died, at least temporarily. At both the second and third advisory committee meetings, the U.S. delegation proposed that the existing 36-nation ECOSOC Commission on Social Development, which supervises all of the activities of the Center for Social Development, be named as the intergovernmental committee responsible for WAA follow-up. The committee agreed to this proposal and it is contained in paragraph 110 of the draft plan of action.

(2) *Interagency coordination.*—After considerable discussion at the second and third advisory committee meetings, the delegations of the Dominican Republic and the United States urged that the existing U.N. interagency committee, which has worked for the past 2 years on the WAA, be retained to coordinate U.N. agency followup action for the WAA. The language recommended to the WAA is contained in paragraph 90 of the draft plan of action.

(3) *U.N. focal point.*—Paragraph 89 of the draft plan of action proposes that the existing U.N. Center for Social Development and Humanitarian Affairs be designated as the U.N. focal point to follow up on the WAA. This is an excellent move and, if adopted, will obviate the creation of a new U.N. institution.

The U.S. delegation at the second and third meeting of the advisory committee also proposed that the Center's aging programs be strengthened in this field by raising the bureaucratic level within the Center from a unit (lowest level in the United Nations) to a branch (three levels higher). The Swedes and the Soviets spoke against this idea. The French and the LDC's supported the idea. We plan to put this idea forward again at the WAA.

(4) *Finance.*—In December 1980, the U.N. General Assembly requested the Secretary General to establish a voluntary fund for the WAA. The United States has now contributed $650,000 to that fund. In November 1981, the U.N. General Assembly requested the Secretary General to use the trust fund "to encourage further interest in the field of aging among developing countries, particularly the least developed among them, within the context of the WAA."

Two paragraphs in the draft plan of action (96 and 97) carry out this mandate from the General Assembly and were supported by the U.S. delegation at the second and third meetings of the advisory committee. Unfortunately, at the third meeting the Swedish and U.S.S.R. delegations disagreed with these paragraphs, while the United States, France, and all the developing country delegations insisted the language be maintained. This fund is purely voluntary in nature, i.e., governments, private corporations, or even private citizens can contribute to it if they so desire, to carry out technical assistance projects for the aging. This issue will be raised by the Swedes and the Soviets at the WAA.

In addition to the above, the U.S. delegation to the second and third advisory committee meetings also proposed that the Center be granted "executing agency"' authority by the U.N. Development Program (UNDP) to carry out technical assistance projects for the aging with UNDP funds. The same split took place again. The U.S. delegation to the WAA will push for insertion of this language in the plan of action.

All of these U.S. initiatives are designed to strengthen the followup activities to the WAA so that the Assembly can address constructively the issues related to aging in the years ahead.

CONCLUSION

The International Plan of Action on Aging will be the centerpiece of the WAA effort and should be adopted by the U.N. General Assembly in December 1982. While this plan will be advisory in nature and will not be binding on member governments, we nevertheless should insure that it is adopted without significant modifications in the form approved by the advisory committee. The plan will provide guidance to governments and will have a certain moral force behind it if it is adopted by consensus at the WAA. That should be our goal.

SPEECH OF HON. RICHARD S. SCHWEIKER, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Madam President, fellow delegates and colleagues: It is indeed a pleasure to be with you today—and to have this opportunity to share with you the perspectives of the United States on the aging of our society.

As I look around this hall, I am reminded of the great diversity of the representatives here. We come from different backgrounds and experience, and from countries with different forms of government.

Yet the issues of aging are universal. They affect us all. They have an enormous impact on the social, economic, and political characteristics of both developed and developing countries. They ask—indeed, demand of us—that we find new and better ways to meet the challenges and opportunities presented by the aging of our world population.

Already we've come a long way.

Once it was fashionable to treat the aging process as somehow a negative one . . . viewing the elderly as a homogenous group . . . focusing only on their problems.

Today we know differently. Medical, scientific, and social advances have blessed our people with longer, healthier lives. Older persons are the fastest growing segment of our population. Their knowledge is a global treasure. They have worked for years growing our food and building our communities. They have dreamed and they have endured, and they have earned the fruits of their labor.

So our challenge here in Vienna is evident—to find personal fulfillment for our elderly through new activities and roles that were not as widely available to earlier generations.

And our opportunity in Vienna is clear—to use the reservoir of experience and knowledge possessed by an increasingly healthier, wealthier, and better educated older population.

As a society, we must seek better use of this rich resource. No energy source, no tool, no economic asset can equal the potential strength of our older citizens. If modern society ignores or shunts aside this valuable resource, it will do so at its own peril, and to its own loss.

That is why this World Assembly on Aging couldn't be more timely—because each of us attending this Assembly can build a strategy . . . not only for coping with aging problems, but also for taking advantage of the promise inherent in the world's growing elderly population.

That promise is staggering—because, according to U.N. estimates, the world's total population will increase almost 50 percent from 1975 to the year 2000. During that same period, the total population over the age of 60 is expected to rise by 70 percent, and by the year 2025 it will represent almost 14 percent of this globe's total population.

In the United States, our elderly population has been growing much faster than our population as a whole. Since the beginning of this century, the number of older Americans has exploded from 4.9 to 34 million—a rate of growth three times higher than for the population under 60.

Today, there are more Americans over 60 than there are teenagers or children aged 10 and under. By the year 2000, there will be some 42 million Americans aged 60 and over—and by the year 2030, nearly one in every four citizens of the United States will be aged. So you can see that in my country—as in yours—we're going to have to anticipate the social changes arising from the larger numbers of older persons in our societies.

Like you, I believe this forum can serve as a catalyst for developing ways to address the aging phenomenon. But because each nation differs in social, political, and economic attributes, effective programs of action must also be implemented at the national and local levels, according to national priorities, and tempered by available resources.

For nearly a century now—ever since increased industrialization and increased awareness of illness and poverty made us more sensitive to the plight of the elderly—the United States has regarded aging as a truly national challenge.

Our Social Security Act of 1935 marked the beginning of major Government attention to the needs of the elderly. Since then, as aging issues have gained in importance, the amount of our resources devoted to needs of the aging have increased tremendously. Today, we have wide-ranging programs that support social services and health research, and that provide direct income support, retirement and disability benefits, health care, education, housing, transportation, social and nutrition services, and much more. Indeed, during the current fiscal year, about 27 percent of the entire U.S. Government's budget is devoted to programs benefiting the elderly. This represents $195 billion for the elderly.

In addition to these resources, anti-age discrimination laws, special tax provisions, and investment incentives are available to the aged. Other supports for the elderly include individual savings and pension plans; assistance from family, friends, and volunteers, from local communities, private nonprofit and religious organizations, and business; and State and local government programs. These support systems are described in detail in the National Report that we have prepared for this Assembly.

In America, all of us have a stake in the "Graying of America." As head of the U.S. Government's largest Department, dedicated to Health and Human Services, I am responsible for most Government aging programs, and I know how profoundly the aging trend will affect the United States in coming years. Key questions must be answered:

—How will aging affect job opportunities and our consumer marketing systems? How will it affect education, politics, and government? How will it affect the response of our health care institutions to demands for services?

—How can we change the very definition of "elderly," as the entire population grows older? How can we enhance the extra decades of life Americans will be living?

—Most important of all, how can we tap the skills and experience of our older citizens so they'll serve as an even more productive force in our society?

These questions were studied last year at my country's major National Conference on Aging.

The 1981 White House Conference on Aging involved over 400,000 older people, service providers, and elected officials in preparatory community and State forums. They shared the belief that I know you hold—the belief that we can find bold new ideas and bold new answers. We need not fear the aging trend.

The Conference participants, including a number of international observers, addressed such issues as the preservation of social security . . . further removal of barriers to independent living . . . health services . . . the supply of housing for the elderly . . . the development of in-home services . . . assistance to families for care of elderely relatives . . . and promotion of employment opportunities.

In the 1981 Conference, several elements were emphasized.

First was the attention devoted to the concerns of older women, reflecting their majority status in the elderly population.

Second was a strong effort to involve representatives of State and local agencies, as well as the business community and other parts of the private sector. This effort reflected President Reagan's desire to help the Federal Government better provide health and social services and to increase participation by State and local government, private and nongovermental organizations, business, and volunteers.

The third element of the 1981 National Conference was a general agreement that because of major advances in health and economic security, the majority of our aging population—like the population as a whole—needs (and wants) less Government interference in their lives.

Above all, we sought to reaffirm the dignity and self-esteem of America's elderly . . . to insure more equality of treatment and opportunity . . . to guarantee, for example, as President Reagan has urged, "When it comes to retirement, the criterion should be fitness for work, not year of birth."

Last month we released the Final Report of the 1981 White House Conference on Aging, which will contribute greatly to developing a positive national aging policy for the 1980's.

Its 53 recommendations parallel many of the recommendations contained in the draft plan of action that we will consider at this Assembly.

They deal with strengthening the income security system . . . with eliminating mandatory retirement requirements in Government and private industry based solely on age . . . with increasing the availability of home and community-based services to avoid unnecessary institutionalization . . . and with placing greater emphasis on preventive health care.

Let me comment briefly on two of these recommendations:

Our administration is committed to eliminating mandatory retirement. We believe that changes in this area will allow older persons to participate more fully in all aspects of American life.

The recommendation of preventive health care is one that especially pleases me, because it concerns a concept I've put at the top of my Department's policy agenda—the concept of showing individuals what they can do to preserve good health and prevent illness before it strikes.

In the United States, we will continue to stress preventive health care and to provide our elderly with the maximum chance to live independent and healthy lives. And as such, we'll continue to encourage serious discussions of the choices we have to make to prepare for the generation that will turn elderly in the 21st century. Our goal is simple—to make America a great place not simply to grow up in—but to grow old in, too.

That goal will challenge us long after we leave Vienna—and to benefit the elderly is a goal that will also challenge you. Fortunately, the Advisory Council of this Assembly has incorporated a number of recommendations for implementation in its draft plan of action. Some of these deal with the commitment of government at all levels to give more attention to the question of aging. They ask that we recognized our population's "coming of age" for what it is—a watershed in our planet's history.

But while each government must act—everyone of us—equally important is action at the global level. We endorse the recommendation that the Commission for Social Development, rather than a newly created body, should have responsibility for overseeing the implementation of the plan of action in the post-Assembly period.

To assist the Commission, the Centre for Social Development and Humanitarian Affairs should have the lead role in the Secretariat for followup to the Assembly. We also believe that the Centre's aging programs should be strengthened by upgrading their organizational setting in the Centre.

But continuing the work we do here—and building upon that work—involves more than U.N. appraisal of action at the national regional, and local levels. It is essential that U.N. bodies—the specialized agencies, the regional commissions, and the Secretariat itself—undertake action programs, especially those designed to assist the developing countries. One proposal deserving study is the developing of closer links between UNDP and the Centre for Social Development and Humanitarian Affairs. In this way, I believe the developing countries can be provided with more effective technical assistance.

Another way to encourage interest in the field of aging among developing countries is through continuation of the World Assembly on Aging Trust Fund. Already, more than 20 countries have pledged $1.5 million to the fund. My own Government has pledged $650,000—and once this Assembly ends, in the weeks and years ahead . . . the fund will serve as a vehicle to support projects for the aging . . . enlisting not only the support of governments, but also the private sector.

If we commit ourselves to a program of action at the global, regional, and local levels as proposed in the plan before this Assembly, we will benefit the elderly of today and, indeed, all of us tomorrow.

Each of us attending this Assembly must continue preparations for the increasing number and increasing proportion of elderly in all of our nations.

Those preparations will mean progress.

Not progress measured merely by adding years to the human lifespan . . . we've already done that . . . but the progress that comes when we add to the quality and purpose of life within that longer lifespan. As the theme of this year's World Health Day stressed: We're not just adding years to life, we're adding life to years.

In the past, we have adapted to major changes in our societies. In the future, there is every reason to believe that we will benefit from the aging phenomenon, too. Together, we will celebrate the triumph of our aging society—in a very real sense, a triumph of life.

Thank you.

INTERNATIONAL PLAN OF ACTION ON AGING

FOREWORD

1. Recognizing the need to call worldwide attention to the serious problems besetting a growing portion of the populations of the world, the General Assembly of the United Nations decided, in Resolution 33/52 of December 14, 1978, to convene a World Assembly on Aging in 1982. The purpose of the World Assembly would be to provide a forum "to launch an international action program aimed at guaranteeing economic and social security to older persons, as well as opportunities to contribute to national development." In its Resolution 35/129 of December 11,, 1980, the General Assembly further indicated its desire that the World Assembly "should result in societies responding more fully to the socioeconomic implications of the aging of

populations and to the specific needs of older persons." It was with these mandates in view that the present draft International Plan of Action on Aging was conceived.

2. The plan of action, when adopted, should therefore be considered an integral component of the major international, regional, and national strategies and programs formulated in response to important world problems and needs. Its primary aims are to strengthen the capacities of countries to deal effectively with the aging of their populations and with the special concerns and needs of their elderly, and to promote an appropriate international response to the issues of aging through action for the establishment of the new international economic order and increased international technical cooperation, particularly among the developing countries themselves.

3. In pursuance of these aims, specific objectives are set:

(a) To further national and international understanding of the economic, social, and cultural implications for the processes of development of the aging of the population.

(b) To promote national and international understanding of the humanitarian and developmental issues related to aging.

(c) To propose and stimulate action-oriented policies and programs aimed at guaranteeing social and economic security for the elderly, as well as providing opportunities for them to contribute to, and share in the benefits of, development.

(d) To prevent policy alternatives and options consistent with national values and goals and with internationally recognized principles with regard to the aging of the population and the needs of the elderly.

(e) To encourage the development of appropriate education, training, and research to respond to the aging of the world's population and to foster an international exchange of skills and knowledge in this area.

4. The plan for action should be considered within the framework of other international strategies and plans. In particular, it reaffirms the principles and objectives of the Charter of the United Nations, the Universal Declaration of Human Rights (General Assembly Resolution 217A (III)), the International Covenants on Human Rights (General Assembly Resolution 2200A (XXI)) and the Declaration on Social Progress and Development (General Assembly Resolution 2542 (XXIV)), the Declaration and the Program of Action on the Establishment of a New International Economic Order (General Assembly Resolutions 3201 (S-VI) and 3202 (S-VI)) and the International Development Strategy for the Third United Nations Development Decade (General Assembly Resolution 35/56) and also General Assembly Resolutions 34/75 and 35/46, declaring the 1980's as the Second Disarmament Decade.

5. In addition, the importance of the following, adopted by the international community, must be stressed, for the question of aging and the aging of populations is directly related to the attainment of their objectives:

(a) The World Population Plan of Action.[1]

(b) The World Plan of Action for the Implementation of the Objectives of the International Women's Year.[2]

(c) The Program of Action for the Second Half of the U.N. Decade for Women.[3]

(d) The Declaration of Alma Ata (on primary health care).[4]

(e) Declaration of Principles of the United Nations Conference on Human Settlements (HABITAT).[5]

(f) The Action Plan for the Human Environment.[6]

(g) The Vienna Program of Action on Science and Technology for Development.[7]

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[1] "Report of the United Nations World Population Conference, Bucharest, 19–30 August 1974" (U.N. publication, sales No. E.75.XIII.3), chap. I.

[2] "Report of the World Conference of the International Women's Year, Mexico City, 19 June to 2 July 1975" (U.N. publication, sales No. E.76.IV.1), chap. I

[3] "Report of the World Conference of the United Nations Decade for Women: Equality, Development and Peace, Copenhagen, 14–30 July 1980" (U.N. publication, sales No. E.80.IV.3 and corrigendum), chap. I, sect. A.

[4] World Health Organization, "Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, Union of Soviet Socialist Republics, 6–12 September 1978" (Geneva, 1978).

[5] "Report of HABITAT: United Nations Conference on Human Settlements, Vancouver, 31 May to 11 June 1976" (U.N. publication, sales No. E.76.IV.7 and corrigendum), chap. I.

[6] "Report of the United Nations Conference on the Human Environment, Stockholm, 5–16 June 1972" (U.N. publication, sales No. E.73.II.A.14 and corrigendum).

[7] "Report of the United Nations Conference on Science and Technology for Development, Vienna, 20–31 August 1979" (U.N. publication, sales No. E.79.II.21 and corrigendum), chap. VII.

(h) Program of Action To Combat Racism and Racial Discrimination[8] and the Program of Action for the Second Half of the Same Decade.[9]

(i) The Buenos Aires Plan of Action for Promoting and Implementing Technical Cooperation Among Developing Countries.[10]

(j) The International Labor Organization (ILO) Convention No. 102 Concerning Minimum Standards of Social Security.

(k) ILO Convention No. 128 and Recommendation 131 on Invalidity, Old-Age, and Survivors' Benefits.

(l) ILO Recommendation No. 162 Concerning Older Workers.

(m) Program of Action of the World Conference on Agrarian Reform and Rural Development.[11]

(n) World Program Resulting From International Year of Disabled Persons.[12]

(o) The Caracas Declaration Adopted by the Sixth United Nations Congress on the Prevention of Crime and the Treatment of Offenders.[13]

(p) Recommendation on the Development of Adult Education—Adopted by the General Conference of UNESCO at Its 19th Session (Nairobi, 1976).

(q) ILO Convention No. 157 Concerning Maintenance of Social Security Rights, 1982.

I. INTRODUCTION

(A) Demographic Background

6. Only in the past few decades has the attention of national societies and the world community been drawn to the social, economic, political, and scientific questions raised by the phenomenon of aging on a massive scale. Previously, while individuals may have lived into advanced stages of life, their numbers and proportion in the total population were not high. The 20th century, however, has witnessed in many regions of the world the control of perinatal and infant mortality, a decline in birth rates, improvements in nutrition, basic health care, and the control of many infectious diseases. This combination of factors has resulted in an increasing number and proportion of persons surviving into the advanced stages of life.

7. In 1950, according to U.N. estimates, there were approximately 200 million persons 60 years of age and over throughout the world. By 1975, that figure had increased to 350 million. U.N. projections to the year 2000 indicate that the number will increase to 590 million, and by the year 2025 to over 1,100 million; that is, an increase of 224 percent since 1975, During this same period, the world's population as a whole is expected to increase from 4.1 to 8.2 billion, an increase of 102 percent. Thus, 45 years from now the aging will constitute 13.7 percent of the world's population.

8. It should be noted, furthermore, that in 1975 slightly over half (52 percent) of all persons 60 and over lived in the developing countries. By the year 2000—owing to the differential rates of increase—over 60 percent of all older persons are expected to live in those countries, and it is anticipated that the proportion will reach nearly three-quarters (72 percent) by 2025.

9. The increase in the numbers and proportions of the aging is accompanied by a change in the population's age structure. A declining proportion of children in a population increases the proportion of older persons. Thus, according to the U.N. projections, the population aged less than 15 years in the developing regions is expected to decline from an average of about 41 percent of the total population in 1975 to 33 percent in 2000 and 26 percent in 2025. In the same regions, the population of 60 years and over is expected to increase from 6 percent in 1975 to 7 percent in 2000 and 12 percent in 2025, thus reaching the level observed in the developed regions in the 1950's. In those latter regions, the population below the age of 15 is expected to decline from 25 percent in 1975 to 21 percent in 2000 and to 20 percent in 2025;

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[8] "Report of the World Conference to Combat Racism and Racial Discrimination, Geneva, 14-25 August 1978" (U.N. publication, sales No. E.79.XIV.2), chap. I.

[9] General Assembly Resolution 34/24, annex.

[10] "Report of the United Nations Conference on Technical Cooperation Among Developing Countries, Buenos Aires, 30 August to 12 September 1978" (U.N. publication, sales No. E.78.II.A.11 and corrigendum), chap. I.

[11] Food and Agriculture Organization of the United Nations, "Report of the World Conference on Agrarian Reform and Rural Development, Rome, 12-20 July 1979" (WCARRD/REP), part 1; transmitted to the members of the General Assembly by a note of the Secretary General (A/34/485).

[12] See A/36/471 Add.1, annex, sect. II.

[13] General Assembly Resolution 35/171, annex.

however, the group 60 and over is expected to see its proportion in the total population increase from 15 percent in 1975 to 18 percent in 2000 and 23 percent in 2025. It should be noted that these are averages for vast regions and that considerable variations exist between countries and at the subnational level.

10. According to model life tables, increasing life expectancy at birth could imply an increase in life expectancies at age 60 in the developed regions of approximately 1 year between 1975 and 2025. In the developing regions, the projected increase would be of roughly 2.5 years. Men of 60 could thus expect an average of over 17 years of further life in the developed regions by 2025 and of over 16 years in the developing regions. Women could expect about an additional 21 and 18 years, respectively.

11. It should be noted that if present trends prevail, the sex ration (that is, the number of men per 100 women) will continue to be unbalanced in the developed regions with however a slight improvement. For instance, this rate, which in 1975 was 74 for the 60–69 age group will be 78 in 2025, with a rise from 48 to 53 for the over–80 age group. In the developing regions, this rate will be 94 in 2025 against 96 for the 60–69 age group, and 73 against 78 for the over–80 age group, signifying a slight decline. Thus, women, in most cases, will increasingly constitute a majority of the older population. Gender-based differences in longevity may have some impact on living arrangements, income, health care and other support systems.

12. Another important consideration is the trend in urban-rural distribution. In the developed regions, two-thirds of the aged were in urban areas in 1975, and this projection is expected to reach three-quarters by the year 2000. In the developing regions, three-quarters of the aged were to be found in rural areas. Nevertheless, the increase in the proportion of the aging in urban areas in these countries could be considerable and exceed 40 percent by the year 2000. These changes can be influenced by migration.

(B) Humanitarian and Developmental Aspects of Aging

13. The demographic trends outlined above will have significant effects on society. The achievement of sustained development requires that a proper balance be preserved between social, economic, and environmental factors and changes in population growth, distribution, and structure. Countries should recognize and take into account their demographic trends and changes in the structure of their populations in order to optimize their development.

For this purpose a substantial financial effort will be needed on the part of governments and the international institutions concerned. Actually, however, the economic situation of most of the developing countries is such that they are unable to release the means and resources needed for carrying out their development policy successfully.

In order to enable these countries to deal with the basic needs of their population, including the elderly, it is necessary to establish a new economic order based on new international economic relations that are mutally beneficial and that will make possible a just and equitable utilization of the available wealth, resources, and technology.

14. The International Plan of Action on Aging deals both with issues affecting the aging as individuals and those relating to the aging of the population.

15. The humanitarian issues relate to the specific needs of the elderly. Although the elderly share many problems and needs with the rest of the population, certain issues reflect the specific characteristics and requirements of this group. The subtopics to be examined are health and nutrition, housing and environment, the family, social welfare, income security and employment, and education.

16. The developmental issues relate to the socioeconomic implications of the aging of the population, defined as an increase in the proportion of the aging in the total population. Under this heading are considered, inter alia, the effects of the aging of the population on production, consumption, savings investment and—in turn—general social and economic conditions and policies, especially at times when the dependency rate of the aging is on the increase.

17. These humanitarian and developmental issues are examined with a view to the formulation of action programs at the national, regional and international levels.

18. In some developing countries, the trend toward a gradual aging of the society has not yet become prominent and may not, therefore, attract the full attention of planners and policymakers who take account of the problems of the aged in their overall economic and social development planning and action to satisfy the basic

needs of the population as a whole. As outlined in the preceding section, however, U.N. projections show that:

(a) A marked increase in the over-60 population is expected in the future, particularly in the segment of those aged 80 years and over.

(b) In many countries, the increase in the proportion of the over-60 population is expected to become apparent over the next few decades, and especially during the first quarter of the 21st century; and

(c) Increasingly women will comprise the majority of these elderly population.

19. The issue of the aging of populations, with its vast implications both for overall development at the national level and for the welfare and safety of older individuals, is therefore one which will concern all countries in the relatively near future; it already affects some of the more developed regions of the world.

19.1 The measures for the optimum utilization of the wisdom and expertise of elderly individuals will be considered.

19.2. The human race is characterized by a long childhood and by a long old age. Throughout history this has enabled older persons to educate the younger and pass on values to them; this role has insured man's survival and progress. The presence of the elderly in the family home, the neighborhood, and in all forms of social life still teaches and irreplaceable lesson of humanity. Not only by his life, but indeed by his death, the older person teaches us all a lesson. through grief the survivors come to understand that the dead do continue to participate in the human community, by the results of their labor, the works and institutions they leave behind them, and the memory of their words and deeds. This may encourage us to regard our own death with greater serenity and to grow more fully aware of our responsibilities toward future generations.

19.3. A longer life provides humans an opportunity to examine their lives in retrospect, to correct some of their mistakes, to get closer to truth, and to achieve a different understanding of the sense and value of their actions. This may well be the more important contribution of older people to the human community. Especially at this time, after the unprecedented changes that have affected humankind in their lifetime, the reinterpretation of life stories by the aged should help us all to achieve the urgently needed reorientation of history.

II. PRINCIPLES

20. The formulation and implementation of policies on aging is the sovereign right and responsibility of each State, to be carried out on the basis of its specific national needs and objectives. However, the promotion of the activities, safety, and well-being of the elderly should be an essential part of an integrated and concerted development effort within the framework of the new international economic order in both the developed and the developing parts of the world. International and regional cooperation should, however, play an important role. The International Plan of Action on Aging is based on the principles set out below.

(a) The aim of development is to improve the well-being of the entire population on the basis of its full participation in the process of development and an equitable distribution of the benefits therefrom. The development process must enhance human dignity and insure equity among age groups in the sharing of society's resources, rights, and responsibilities. Individuals, regardless of age, sex, or creed should contribute according to their abilities and be served according to their needs. In this context, economic growth, productive employment, social justice, and human solidarity are fundamental and indivisible elements of development, so are the preservation and recognition of cultural identity.

(a.1) Various problems of older people can find their real solution under conditions of peace, security, a halt to the arms race, and a rechanneling of resources spent for military purposes to the needs of economic and social development.

(b) The developmental and humanitarian problems of the aging can best find their solution under conditions where tyranny and oppression, colonialism, racism, discrimination based on race, sex, or religion, apartheid, genocide, foreign aggression and occupation, and other forms of foreign aggression and occupation, and other forms of foreign domination do not previal, and where there is respect for human rights.

(c) In the context of its own traditions, structures, and cultural values, each country should respond to demographic trends and the resulting changes. People of all ages should engage in creating a balance between traditional and innovative elements in the pursuit of harmonious development.

(d) The spiritual, cultural, and socioeconomic contributions of the aging are valuable to society and should be so recognized and promoted further. Expenditure on the aging should be considered as a lasting investment.

(e) The family, in its diverse forms and structures, is a fundamental unit of society linking the generations and should be maintained, strengthened, and protected, in accordance with the traditions and customs of each country.

(f) Governments, and in particular local authorities, nongovernmental organizations, individual volunteers, and voluntary organizations, including associations of the elderly, can make a particularly signficant contribution to the provision of the support and care for elderly people in the family and community. Governments should sustain and encourage voluntary activity of this kind.

(g) An important objective of socioeconomic development is an age-integrated society, in which age discrimination and involuntary segregation are eliminated and in which solidarity and mutual support among generations is encouraged.

(h) Aging is a lifelong process and should be recognized as such. Preparation of the entire population for the later stages of life should be an integral part of social policies and encompass physical, psychological, cultural, religious, spiritual, economic, health, and other factors.

(i) The plan of action should be considered within the broader context of the world's social, economic, cultural, and spiritual trends, in order to achieve a just and prosperous life for the aging, materially as well as spiritually.

(j) Aging, in addition to being a symbol of experience and wisdom, can also bring human beings closer to personal fulfillment, according to their beliefs and aspirations.

(k) The aging should be active participants in the formulation and implementation of policies, including those especially affecting them.

(l) Governments, nongovernmental organizations, and all concerned, have a special responsibility to the most vulnerable among the elderly, particularly the poor of whom many are women and from rural areas.

(m) Further study on all aspects of aging is necessary.

III. RECOMMENDATIONS FOR ACTION

(A) Goals and Policy Recommendations

21. The plan of action can only include proposals for broad guidelines and general principles as to the ways in which the international community, governments, other institutions, and society at large can meet the challenge of the progressive aging of societies and the needs of the elderly all over the world. More specific approaches and policies must, by their nature, be conceived of and phrased in terms of the traditions, cultural values, and practices of each country or ethnic community—and programs of action must be adapted to the priorities and material capacities of each country or community.

22. There are, nevertheless, a number of basic considerations which reflect general and fundamental human values, independent of culture, religion, race, or social status—values induced by the biological fact that aging is a common and ineluctable process. The respect and care for the elderly, which has been one of the few constants in human culture everywhere, reflects a basic interplay between self-preserving and society-preserving impulses which has conditioned the survival and progress of the human race.

23. The pattern by which people are somehow judged to have reached old age at a point set only in terms of the number of years they have completed, and where the loss of employment status may entail their being placed on the sidelines of their own society, is one of the sad paradoxes of the process of socioeconomic development in some countries. The aim of that development was originally to improve the general living standards, health and well-being of the population at large, including the elderly.

24. The close historical interaction between the socioeconomic and technological development of the industrialized countries from the last century onwards, and the old-age security systems they adopted as a part of the same process, should be analyzed and kept in mind; however, other options corresponding more closely to the circumstances and needs of the developing countries ought also to be considered.

25. Aging is simultaneously a sign of and a result of socioeconomic development, in the quantitative as well as the qualitative sense. One major example of the effects of the imbalance between the sectoral approaches taken to national and international development during the past decades is the fact that advances in medicine and public health have by far outpaced progress over the same period in production,

income distribution training, education, housing, institutional modernization, and social development in general terms. The developing countries are in this sense about to "age"; without all the sectors necessary to insure balanced and integrated development being able to follow at the same pace and guarantee a decent living standard for the dramatically increasing numbers of elderly people foreseen for the next few generations.

(1) General policy recommendations

26. The following summarized considerations, based on the above remarks, may provide guidelines for the discussion of policies and specific actions:

(a) The progressive aging of societies, the continuing increase of the elderly population both in absolute and proportional terms, is neither an unexpected, unforeseeable event nor a random result of national and international development efforts. It is the first and most visible outcome of a sectorally based approach to socioeconomic development all over the world and should be accompanied by equally efficient interventions in other areas in order to insure balanced growth and integrated development.

(a.1) With a long-term view to slowing down the overall aging of the community, governments may be able to take the measures necessary to adjust or avoid imbalances between age groups, while preserving the right to life of the elderly.

(b) To this end, policies and actions should be inspired by the determination to give further qualitative content and meaning to a quantitative process in order to make sure that the generally expanding lifespan of individuals the world over will be accompanied by efforts to fill these extra years with a sense of purpose and accomplishment, and that people will not be relegated to a marginal and passive role after a certain age level.

(c) As the transition into old age is a gradual and individual process, notwithstanding the statutory retirement age limits adopted in some countries and cultures, all policies and programs should be based on the fact that aging is a natural phase of an individual's life cycle, career, and experience, and that the same needs, capacities, and potentialities usually prevail over the entire lifespan.

(d) As most people can expect to survive their own retirement age by a substantial number of years, the concept of "preparation for retirement" should not continue to be conceived as a last-minute adaptation, but be proposed as a lifelong consideration from adulthood onwards—as much to the individual for his or her future benefit, as to policymakers, universities, schools, industrial work centers, the media, and society at large. It should serve as a reminder that policies on aging and for the elderly are an important societywide concern, and not solely a question of caring for a vulnerable minority. For this reason, this calls for a general policy of prevention.

(e) Policies to meet the challenge of a growing, healthier, and more active elderly population—based on the view of the aging of society as an opportunity to be utilized—automatically benefit the individual aging person, materially and otherwise. Similarly, any effort to ameliorate the quality of life for the elderly, and to meet their diverse social and cultural needs, enhances their capacity to continue interacting with society. In this sense, the developmental and the humanitarian aspects of the question of aging are closely intertwined.

(f) It is imperative that, when considering the question of aging, the situation of the elderly should not be considered separate from the overall socioeconomic conditions prevailing in society. The elderly should be viewed as an integral part of the population. They should also be considered within the framework of population groups such as women, youth, the disabled, and migrant workers. The elderly must be considered an important and necessary element in the development process at all levels within a given society.

(f.1) Aging is apparent in the working-age population long before the number of persons over 60 increases. It is essential to adapt the labor policy as a whole and technology and economic organizations to this situation.

(g) This consideration should be accompanied by recognition of the fact that for the elderly in general—and particularly for those beyond a certain higher age (the "old old")—policies have to be considered and programs implemented in response to their specific needs and constraints. Sectoral interventions in such fields as health and nutrition, housing, income security, and social, cultural, and leisure activities are as necessary for the elderly as for other population groups, and should be provided by each country or community according to the means available to it. It is recognized that the extent of the provision that can be made, and its timing, will be affected by prevailing economic circumstances.

(h) Policies and action aimed at benefiting the aging must afford opportunities for older persons to satisfy the need for personal fulfillment, which can be defined in its broader sense as satisfaction realized through the achievement of personal goals, aspirations, and potentialities. It is important that policies and programs directed at the aging promote opportunities for self-expression in a variety of roles challenging to themselves and contributory to family and community. The principal ways in which older people find personal satisfaction are through: Continued participation in the family and kinship system, voluntary services to the community, continuing growth through formal and informal learning, self-expression in arts and crafts, participation in community organizations and organizations of older people, religious activities, recreation and travel, part-time work, and participation in the political process as informed citizens.

27. A priority consideration for all countries is how to insure that their vast humanitarian efforts in favor of the elderly do not result in the maintenance of a growing, relatively passive, and disenchanted sector of the population. Policymakers and researchers as well as the mass media and the general public, may need a radical change of perspective in order to appreciate that the problem of aging today is not just one of providing protection and care, but of the involvement and participation of the elderly and the aging. Eventually, the transition to a positive, active, and developmentally oriented view of aging may well result from action by elderly people themselves, through the sheer force of their growing numbers and influence. The collective consciousness of being elderly, as a socially unifying concept, can in that way become a positive factor. Since spiritual well-being is as important as material well-being, all policies, programs, and activities should be developed to support and strengthen spiritual well-being of the aging. Governments should guarantee the freedom of religious practices and expressions.

(2) The impact of aging on development

28. The trend toward the successive aging of population structures is bound to be one of th main challenges to international and national planning efforts during the last decades of this century and well into the 21st. In addition to the general considerations outlined above on the status and predicaments of the elderly sections of societies, and the review of the needs and potentialities of the elderly, attention should be given to the vast and multifaceted impact which the aging of populations will have on the structure, functioning, and further development of all societies of the world. The role of the public and private sectors in assuming responsibility for some of the functions now provided by the family in developing countries will probably have to increase under such circumstances.

29. In the first instance, it is evident that aging, both in terms of absolute numbers and with regard to the relative proportion of the elderly in any society, will necessarily change the structure and composition of the economically active population. The most basic manifestation of this phenomenon will be the gradually deteriorating ratios between the economically active and employed sectors of society and those dependent for their sustenance on the material resources provided by these sectors. Countries with established social security systems will depend on the strength of the economy to sustain the accumulated charges of income bases and deferred retirement benefits for a growing elderly population and the costs of maintaining dependent children and of insuring training and education for young people.

30. Changing dependency ratios—in terms of the number of old people depending for their material safety on younger, economically active, and wage-earning people—are bound to influence the development of any country in the world, irrespective of its social structure, traditions, or formal social security arrangements. Problems of a social nature are likely to emerge in countries and regions where the aging have traditionally benefited from the care and protection of their next of kin or the local community. Those relationships may become increasingly difficult to maintain when the number of dependent elderly increases while at the same time traditional care-providing structures, such as the extended family, are undergoing radical change in many regions of the world.

31. As mentioned above, the total dependency ratio in many countries may eventually be maintained at close to present levels, owing to the progressively decreasing number of nonemployed and dependent children and youth resulting from shrinking birth rates. There remains, however, a political and psychological problem related to the perceptions of the relative urgency of covering the material and other needs of population groups not directly participating in production and public life. The costs of programs in favor of the younger generations may be more easily acceptable in view of their value as a form of investment in the future; conversely, such costs in

favor of the elderly—especially when not directly related to individual savings or wage-related benefits—are less easily accepted, particularly when they weigh heavily on already overstrained national budgets.

32. The problem of deteriorating dependency ratios, and hence of guaranteeing even minimal material security for older people with reduced capacities for earning, will be most acute in the rural areas—particularly in the less-productive, subsistence farming areas of the developing countries, which already suffer from an escalating flight of the younger and more active sectors of the population toward the urban areas in search of salaried employment. This trend naturally leads to an even more insecure future for the older persons left behind and—in a vicious circle of further deprivation—reduces the chances of further stimulating public investment in agriculture and services which would benefit the remaining farmers.

33. To some extent this phenomenon could be considered as partially offset or at least mitigated by the transfer of sustenance funds back from the younger people who have found salaried employment in the urban and industrialized areas. In many cases, the size of the remittances indicates an effort not only to help sustain the family, but to save for future investments, productive or not. For the immediate future, this phenomenon may help to soften the effects of the rural exodus and provide a certain level of material safety for the older and inactive left behind. Nevertheless, it can hardly be seen as a long-term reliable compensation for the migration of the young, active people from the rural areas or from their own countries. Concentrated efforts aimed at improving the socioeconomic conditions prevailing in rural areas are indispensable, particularly considering the migrants return to their country of origin.

34. Rural development should be seen as a key to the overall problem of the aging in large parts of the world, as much as it is a key to balanced and integrated national progress in countries with an essentially agricultural economy. To some extent, policies to improve production and productivity in rural areas, to stimulate investment, create the necessary infrastructures, introduce appropriate technologies, and provide basic services, could strengthen the generalized social security systems in force in other and more industrialized countries.

35. The slowly expanding lifespan of the population, even in developing areas, constitutes a hidden resource for national economies which, if properly stimulated and utilized, might help to compensate for the exodus of younger people, decrease the real dependecy ratios, and insure the status of the rural elderly as active participants in national life and production, rather than as passive and vulnerable victims of development.

36. A desirable compension for the emigration of young people to other countries would be an improvement in the continuity of social benefits in terms of contributive rights to a pension, including favorable provisions for financial transfers in whatever form the benefits are granted to migrant workers. This would be not only equitable, but also migrant workers. This would be not only equitable, but also consistent with the stimulation of the development of the economy of the home country. Social security bilateral and multilateral agreements must be developed to this effect. Other measures should accompany these efforts, notably in terms of providing housing for repatriates. While aging migrants have the same needs as other elderly people, their migrant status gives rise to additional economic, social, cultural, and spiritual needs. In addition, it is important to recognize the role the older migrants could play in the support of their younger counterparts.

37. In countries with fully developed social security systems linked to compulsory retirement age levels, overall aging is, and will continue to be, one of the most important structural factors affecting the composition of the labor force. This phenomenon should not be considered solely in terms of its repercussions on the elderly. Because of their sheer dimension and close interaction with other sectors and processes affecting the active labor force, retirement policies cannot be treated in an isolated manner as a separate phenomenon. For various countries the most visible relationship is, of course, that between arrangements for retirement and problems of unemployment, especially among young people about to enter the labor force.

38. Much has already been said about that relationship, and various governmental actions have been considered or taken to respond to it. Whatever the apparent wisdom of lowering retirement age levels in order to open up employment opportunities for the young, such action can hardly be seen as anything but a short-term and partial solution of one social problem through the creation of another, probably longer lasting one. More innovative actions should be considered at both extremes of the labor force structure.

39. On the other hand, the wide varieties in personal interests and preferences among people approaching retirement age could, without too many administrative

or organizational changes, be taken into account in a system of elastic retirement plans catering to the individual. Where retirement is preferred, different age levels for voluntary early retirement can be established with reduced benefits and counter-balanced by extended employment periods for those older persons whose job constitutes their main commitment, and occasionally their main reason for living. Other arrangements, such as part-time or occasional work or consultancies are already in use, especially at the higher technological and administrative levels, and could be extended to a greater part of the labor force. In order to implement this measure, provisions for training and retraining and the development of new skills should be included.

40. The interrelationship between the employment and income needs of the young and the elderly raises particularly acute problems for women, whose longer life expectancy may mean an old age aggravated by economic need, isolation, and with little or no prospects for paid employment.

41. Where social security systems based on accrued retirement benefits exist, the growth in the number and longevity of retired persons is now emerging as a major aspect of the husbandry of national economic resources, and is sometimes presented in terms of a gradual freezing of a large share of national wealth for so-called nonproductive purposes. On the contrary, it will probably be recognized that the accumulation of retirement funds could constitute a stabilizing factor in the national economy, in the sense of providing for long-term and conservatively utilized sources of funding on a substantial scale, whose impact on otherwise fluctuating economic systems can be beneficial. In such systems, the purchasing power of the pensions paid should as far as possible be maintained.

42. Similarly, most pension payments from retirement funds represent deferred earnings by the individual retiree. The natural use of pension payments for immediate material needs rather than for long-term and insecure investments may also be a stimulating factor in societies heavily dependent on individual spending and consumption for their economic health.

43. Where formal retirement benefit systems do not yet exist, the economic implications of the aging of societies are for the time being largely negative, and will probably continue to be so, unless serious and far-reaching efforts are made to turn this liability into a potential benefit for the whole of society. Governmental initiatives to promote material development and social well-being, and international action to sustain such initiatives, could be taken jointly in an effort to prepare for the future of those approaching old age in areas where traditional structures of protection are about to dissolve.

(3) Areas of concern to aging individuals

44. The recognition that all aspects of aging are interrelated implies the need for a coordinated approach to policies and research on the subject. Considering the aging process in its totality, as well as its interaction with the social and economic situation, requires an integrated approach within the framework of overall economic and social planning. Undue emphasis on specific sectoral problems would constitute a serious obstacle to the integration of aging policies and programs into the broader development framework. Although the recommendations in the following narrative have been divided under broad headings, for ease of discussion, it should be recognized that there is a high degree of interdependence among them.

45. Within the framework of recognizing this interdependence, particular attention could be given to coordinate preventive efforts in order to combat the detrimental effects of premature aging.

—An educational effort designed specifically to make young people aware of the changes which will occur as they grow older.

—A healthy general lifestyle.

—Appropriate adjustments to working hours and conditions.

—Splitting up each individual's time and responsibilities among various types of activities so that he can have several different jobs as he grows older, and achieve the best possible balance between time spent in leisure, training, and work.

—Constant adaptation of the man to his work and, more important, the work to the man, and changing the type of work in accordance with the changes in each person, in family circumstances, and in technological and economic development. In this sphere, occupational medicine and permanent education should play an essential role.

46. In Resolution 1981/62, the Economic and Social Council called upon the Secretary General to elaborate a set of general guidelines for consumer protection. Furthermore, FAO has adopted a Code of Ethics on International Trade in Food, and

WHO an International Code of Marketing of Breast Milk Substitutes to protect children's health. Elderly consumers should be protected, since the good health, safety, and well-being of the elderly are the objective of the World Assembly on Aging.

(a) Health and nutrition

47. While the rapidly increasing number of old people throughout the world represents a biological success for humanity, the living conditions of the elderly in most countries have by and large lagged behind those enjoyed by the economically active population. But health, that state of total physical, mental, and social well-being, is the result of interaction between all the sectors which contribute to development.

48. Epidemiological studies suggest that successive cohorts of the elderly arriving at the same age have better levels of health, and it is expected that, as men and women live to increasingly greater ages, major disabilities will largely be compressed into a narrow age range just prior to death.

Recommendation 1

Care designed to alleviate the handicaps, reeducate remaining functions, relieve pain, maintain the lucidity, comfort, and dignity of the affected, and help them to reorient their hopes and plans, particularly in the case of the elderly, are just as important as curative treatment.

Recommendation 2

The care of elderly persons should go beyond disease orientation and should involve their total well-being, taking into account the interdependence of the physical, mental, social, spiritual, and environmental factors. Health care should therefore involve the health and social sectors and the family in improving the quality of life of older persons. Health efforts, in particular primary health care as a strategy, should be directed at enabling the elderly to lead independent lives in their own family and community for as long as possible instead of being excluded and cut off from all activities of society.

49. There is no doubt that, with advancing age, pathological conditions increase in frequency. Furthermore, the living conditions of the elderly make them more prone to risk factors that might have adverse effects on their health (e.g., social isolation and accidents)—factors that can be modified to a great extent. Research and practical experience have demonstrated that health maintenance in the elderly is possible and that diseases do not need to be essential components of aging.

Recommendation 3

Early diagnosis and appropriate treatment is required as well as preventive measures, to reduce disabilities and diseases of the aging.

Recommendation 4

Particular attention should be given to providing health care to the very old, and to those who are incapacitated in their daily lives. This is particularly true when they are suffering from mental disorders or from failure to adapt to the environment; mental disorders could often be prevented or modified by means that do not require placement of the affected in institutions, such as training and supporting the family and volunteers by professional workers, promoting ambulant mental health care, welfare work day care, and measures aimed at the prevention of social isolation.

50. Some sectors of the aging, and especially the very old, will nevertheless continue to be vulnerable. Because they may be among the least mobile, this group is particularly in need of primary care from facilities located close to their residences and/or communities. The concept of primary health care incorporates the use of existing health and social services personnel, with the assistance of community health officers trained in simple techniques for caring for the elderly.

51. Early diagnosis and treatment are of prime importance in the prevention of mental illness in older people. Special efforts need to be taken to assist older persons who have mental health problems or who are at high risk in this respect.

52. Where hospital care is needed, application of the skills of geriatric medicine enables a patient's total condition to be assessed and, through the work of a multidisciplinary team, a program of treatment and rehabilitation to be devised, which is geared to an early return to the community and the provision there of any necessary continuing care. All patients should receive, in proper time, any form of inten-

sive treatment which they require, with a view to preventing complications and functional failure leading to permanent invalidity and premature death.

Recommendation 5

Attentive care for the terminally ill, dialog with them, and support for their close relatives at the time of loss, and later require special efforts which go beyond normal medical practice. Health practitioners should aspire to provide such care. The need for these special efforts must be known and understood by those providing medical care and by the families of the terminally ill and by the terminally ill themselves. Bearing these needs in mind, exchange of information about relevant experiences and practices found in a number of cultures should be encouraged.

53. A proper balance between the role of institutions and that of the family in providing health care for the elderly—based on recognition of the family and the immediate community as the key elements in a well-balanced system of care—is important.

54. Existing social services and health care systems for the aging are becoming increasingly expensive. Means of halting or reversing this trend and of developing social systems together with primary health care services need to be considered, in the spirit of the Declaration of Alma Ata.

Recommendation 6

The trend toward increased costs of social services and health care systems should be offset through closer coordination between social welfare and health care services both at the national and community levels. For example, measures need to be taken to increase collaboration between personnel working in the two sectors and to provide them with interdisciplinary training. These systems should, however, be developed, taking into account the role of the family and community—which should remain the interrelated key elements in a well-balanced system of care. All this must be done without detriment to the standard of medical and social care of the elderly.

55. Those who give most direct care to the elderly, are often the least trained, or have insufficient training for their purpose. To maintain the well-being and independence of the elderly through self-care, health promotion, prevention of disease, and disability requires new orientation and skills, which should be made available to the elderly themselves, as well as to their families, and health and social welfare workers in the local communities.

Recommendation 7

(a) The population at large should be informed in regard to dealing with the elderly who require care. The elderly themselves should be educated in self-care.

(b) Those who work with the elderly at home, or in institutions, should receive basic training for their tasks, including the importance of participation of the elderly and their families, and collaboration between workers in health and welfare fields at various levels.

(c) Practitioners and students in the human care professions (e.g., medicine, nursing, social welfare, etc.) should be trained in principles and skills in the relevant areas of gerontology, geriatrics, psychogeriatrics, and geriatric nursing.

56. All too often, old age is an age of no consent. Decisions affecting aging citizens are frequently made without the participation of the citizens themselves. This applied particularly to those who are very old, frail, or disabled. Such people should be served by flexible systems of care that give them a choice as to the type of amenities and the kind of care they receive.

Recommendation 8

The control of the lives of the aging should not be left solely to health, social service, and other caring personnel, since aging people themselves usually know best what is needed and how it should be carried out.

Recommendation 9

Participation of the aged in the development of health care and the functioning of health services should be encouraged.

57. A fundamental principle in the care of the elderly should be to enable them to lead independent lives in the community for as long as possible.

Recommendation 10

Health and health-allied services should be developed to the fullest extent possible in the community. These services should include a broad range of ambulatory services such as: Day care centers, outpatient clinics, day hospitals, medical and nursing care, and domestic services. Emergency services should be always available. Institutional care should always be appropriate to the needs of the elderly. Inappropriate use of beds in health care facilities should be avoided. In particular, those not mentally ill should not be placed in mental hospitals. Health screening and counseling should be offered through geriatric clinics, neighborhood health centers, or community sites where older persons congregate. The necessary health infrastructure and specialized staff to provide thorough and complete geriatric care should be made available. In the case of insitutional care, alienation through isolation of the aged from society should be avoided, inter alia, by further encouraging the involvement of family members and volunteers.

58. Nutritional problems, such as deficient quantity and inappropriate constituents, are encountered among the poor and underprivileged elderly in both the developed and the developing countries. Accidents are also a major risk area for the elderly. The alleviation of these problems may require a multisectoral approach.

Recommendation 11

The promotion of health, the prevention of disease, and the maintaining of functional capacities among elderly persons should be actively pursued. For this, an assessment of the physical, psychological, and social needs of the group concerned is a prerequisite. Such an assessment would enhance the prevention of disability, early diagnosis, and rehabilitation.

Recommendation 12

Adequate, appropriate, and sufficient nutrition, particularly the adequate intake of protein, minerals, and vitamins, is essential to the well-being of the elderly. Poor nutrition is exacerbated by poverty, isolation, maldistribution of food, and poor eating habits including those due to dental problems. Therefore special attention should be paid to:

(a) Improvement of the availability of sufficient foodstuffs to the elderly through appropriate schemes and encouraging the aged in rural areas to play an active role in food production.

(b) A fair and equitable distribution of food, wealth, resources, and technology.

(c) Education of the public including the elderly in correct nutrition and eating habits both in urban and rural areas.

(d) Provision of health and dental services for early detection of malnutrition and improvement of mastication.

(e) Studies of the nutritional status of the elderly at the community level with steps to correct any unsatisfactory local conditions.

(f) Extension of research into the role of nutritional factors in the aging process to communities in developing countries.

Recommendation 13

Efforts should be intensified to develop home care to provide high quality health and social services in the quantity necessary so that older persons are enabled to remain in their own communities to live as independently as possible for as long as possible. Home care should not be viewed as an alternative to institutional care; rather, the two are complementary to each other and should so link into the delivery system that older persons can receive the best care appropriate to their needs at the least cost.

Special support must be given to home care services, by providing them with sufficient medical, paramedical, nursing, and technical facilities of the required standard to limit the need for hospitalization.

Recommendation 14

A very important question concerns the possibilities of preventing or at least postponing the negative functional consequences of aging. Many lifestyle factors may have their most pronounced effects during old age when the reserve capacity usually is lower.

The health of the aging is fundamentally conditioned by their previous health and, therefore, lifelong health care starting with young age is of paramount importance; this includes preventive health, nutrition, exercise, the avoidance of health-harming habits and attention to environmental factors, and this care should be continued.

Recommendation 15

The health hazards of cumulative noxious substances—including radioactive and trace elements and other pollutions—assume a greater importance as lifespans increase and should, therefore, be the subject of special attention and investigation along all lifespan.

Governments should promote the safe handling of such materials in use, and move rapidly to assure waste materials from such use are permanently and safely removed from man's biosphere.

Recommendation 16

As avoidable accidents represent a substantial cost both in human suffering and in resources, priority should be given to measures to prevent accidents in the home, on the road, and those precipitated by treatable medical conditions or by inappropriate use of medication.

Recommendation 17

International exchange and research cooperation should be promoted in carrying out epidemiological studies on local patterns of health and diseases and their consequences together with investigating the validity of different care delivery systems including self-care, and home care by nurses, and in particular of ways of achieving optimum program effectiveness; also investigating the demands for various types of care and developing means of coping with them paying particular attention to comparative studies regarding the achievement of objectives and relative cost-effectiveness; and gathering data on the physical, mental, and social profiles of aging individuals in various social and cultural contexts including attention to the special problems of access to services in rural and remote areas—in order to provide a sound basis for future action.

Recommendation 18

Government should:

(a) Insure that food and household products, installations, and equipment conform to standards of safety that take into account the vulnerability of the aged.

(b) Encourage the safe use of medications, household chemicals, and other products by requiring manufacturers to include necessary warnings and instructions for use.

(c) Facilitate the availability of medications, hearing aids, dentures, glasses, and other prosthetics to the elderly so that they can prolong their activities and independence.

(d) Restrain the intensive promotion and other marketing techniques primarily aimed at exploiting the meager resources of the elderly.

Government bodies should cooperate with nongovernmental organizations on consumer education programs.

Relevant international organizations are urged to promote collective efforts by their Member States to protect elderly consumers.

(b) Housing and environment

59. Adequate living accommodation and agreeable physical surroundings are necessary for the well-being of all people, and it is generally accepted that housing has a great influence on the quality of life of any age group in any country. Suitable housing is even more important to the elderly, whose abodes are the center of virtually all of their activities. Adaptations to the home, the provision of practical domestic aids to daily living, and appropriately designed household equipment can make it easier for those elderly people whose mobility is restricted or who are otherwise disabled to continue to live in their own homes.

60. The elderly meet a manifold of problems when they participate in traffic and transport. Especially elderly pedestrians have to cope with objective or subjectively felt dangers that restrict and limit their mobility and participatory aspirations. The traffic circumstances should be adapted to older people instead of the other way around. Measures and facilities should include traffic education, speed limits espe-

cially in human settlements, traffic safe environments, accommodations, and means of transport, etc.

Recommendation 19

Housing for the elderly must be viewed as more than mere shelter. In addition to the physical, it has psychological and social significance, which should be taken into account. To release the aged from dependence on others, national housing policies should pursue the following goals.

(a) Helping the aged to continue to live in their own homes as long as possible, provision being made for restoration and development and, where feasible and appropriate, the remodeling and improvement of homes and their adaptation to match the ability of the aged to get to and from them and use the facilities.

(b) Planning and introducing—under a housing policy that also provides for public financing and agreements with the private sector—housing for the aged of various types to suit the status and degree of self-sufficiency of the aged themselves, together with local tradition and customs.

(c) Coordinating policies on housing with those concerned with community services (social, health, cultural, leisure, communications) so as to secure, whenever possible, an especially favorable position for housing the aged vis-a-vis dwellings for the population at large.

(d) Evolve and apply special policies and measures, and make arrangements so as to allow the aged to move about and to protect them from traffic hazards.

(e) Such a policy should, in turn, form part of the broader policy of support for the least well-off sectors of the population.

Recommendation 20

Urban rebuilding and development planning and law should pay special attention to the problems of the aging, assisting in securing their social integration.

Recommendation 21

National governments should be encouraged to adopt housing policies that take into account the needs of the elderly and the socially disadvantaged. A living environment designed to support the functional capacities of this group and the socially disadvantaged should be an integral part of national guidelines for human settlements policies and action.

Recommendation 22

Special attention should be paid to environmental problems and to designing a living environment that would take into account the functional capacity of the elderly and facilitate mobility and communication through the provision of adequate means of transport.

The living environment should be designed, with support from governments, local authorities, and nongovernmental organizations, so as to enable elderly people to continue to live, if they so wish, in locations that are familiar to them, where their involvement in the community may be of longstanding and where they will have the opportunity to lead a rich, normal, and secure life.

Recommendation 23

The growing incidence of crime in some countries against the elderly victimizes not only those directly involved, but the many older persons who become afraid to leave their homes. Efforts should be directed to law enforcement agencies and the elderly to increase their awareness of the extent and impact of crime against older persons.

Recommendation 24

Whenever possible the aging should be involved in housing policies and programs for the elderly population.

(c) Family

61. The family, regardless of its form or organization, is recognized as a fundamental unit of society. With increasing longevity, four- and five-generation families are becoming common throughout the world. The changes in the status of women, however, have reduced their traditional role as caretakers of older family members;

it is necessary to enable the family as a whole, including its male members, to take over and share the burden of help in and by the family. Women are entering and remaining in the labor force for longer periods of time. For many who have completed their child-rearing roles, they become caught between the desire and need to work and earn income and the responsibility of caring for elder parents or grandparents.

Recommendation 25

As the family is recognized as a fundamental unit of society, efforts should be made to support, protect, and strengthen it in agreement with each society's system of cultural values and in responding to the needs of its aging members. Governments should promote social policies encouraging the maintenance of family solidarity among generations, with all members of the family participating. The role and contribution of the nongovernmental organizations in strengthening the family as a unit should also be stressed at all levels.

Recommendation 26

Appropriate support from the wider community, available when and where it is needed, can make a crucial difference to the willingness and ability of families to continue to care for elderly relatives. Planning and provision of services should take full account of the needs of those carers.

62. There is ample evidence of the high esteem in which older people are held in developing countries. Trends toward increasing industrialization and urbanization and greater mobility of the labor force indicate, however, that the traditional concept of the role of the elderly in the family is undergoing major change. Worldwide, the overall responsibility of the family to provide the traditional care and support needs of the aging is diminishing.

Recommendation 27

Ways to insure continuity of the vital role of the family and the dignity, status, and security of the aging, taking into account all the internal and international events which might influence this status of security, are issues that deserve careful consideration and action by governments and nongovernmental organizations. Recognizing the predominance of older women, and the relatively greater numbers of widows than widowers throughout the world, particular consideration should be given to the special needs and roles of this group.

Recommendation 28

Governments are urged to adopt an age/family integrated approach to planning and development which would recognize the special needs and characteristics of older persons and their families. Older persons should be included in the governmental and other decisionmaking processes in the political, social, cultural, and educational areas among others, and children should be encouraged to support their parents.

Recommendation 29

Governments and nongovernmental bodies should be encouraged to establish social services to support the whole family when there are elderly people at home and to implement measures especially for low-income families who wish to keep elderly people at home.

(d) Social welfare

63. Social welfare services can be instruments of national policy and should have as their goal the maximizing of the social functioning of the aging. They should be community-based and provide a broad range of preventive, remedial, and developmental services for the aging, to enable them to lead as independent a life as possible in their own home and in their community, remaining active and useful citizens.

In relation to elderly migrants appropriate measures should be taken to provide social welfare services in accordance with their ethnical, cultural, linguistic, and other characteristics.

Recommendation 30

Social welfare services should have as their goal the creation, promotion, and maintenance of active and useful roles for the elderly for as long as possible in and for the community.

64. In many countries where resources are scarce, there is a general lack of organized social welfare services, particularly in the rural areas. Although the role of governments in providing such services is paramount, the contribution of nongovernmental organizations is also of great importance.

In traditional societies, old people have always enjoyed a privileged position based on respect, consideration, status, and authority. But this is starting to be upset under the influence of modern trends and that privileged position is now being questioned. It is therefore time to become aware of these changes and on that basis to define national aging policies that would avoid some of the problems concerning the elderly faced by some developed countries.

Recommendation 31

Existing formal and informal organizations should consider the particular needs of the aging and allow for them in their programs and future planning. The important role that cooperatives can play in providing services in this area should be recognized and encouraged. Such cooperatives could also benefit from the participation of elderly people as full members or consultants. A partnership should be formed between governments and nongovernmental organizations designed to insure a comprehensive, integrated, coordinated, and multipurpose approach to meeting the social welfare needs of the elderly.

Recommendation 32

The involvement of young people—in providing services and care in participating in activities for and with the elderly—should be encouraged, with a view to promoting intergenerational ties. Mutual self-help among the able and active elderly should be stimulated to the extent possible, as should the assistance this group can provide to its less fortunate peers, and the involvement of the elderly in informal part-time occupations.

Recommendation 33

Governments should endeavor to reduce or eliminate fiscal or other constraints on informal and voluntary activities, and eliminate or soften regulations which hinder or discourage part-time work, mutual self-help, and the use of volunteers alongside professional staff in providing social services or in institutions for the elderly.

Recommendation 34

Whenever institutionalization is necessary or inevitable for elderly persons, the utmost effort must be made to insure a quality of institutional life corresponding to normal conditions in their communities, with full respect for their dignity, beliefs needs, interests, and privacy; States should be encouraged to define minimum standards to insure higher quality of institutional care.

Recommendation 35

In order to facilitate mutual help among the elderly and let their voices be heard, governments and nongovernmental bodies should encourage the establishment and free initiative of groups and movements of elderly persons and also give other age groups opportunities for training in, and information on, the support of the elderly.

(e) Income security and employment

65. Major differences exist between the developed and the developing countries—and particularly between urban, industrialized, and rural, agrarian economies—with regard to the achievement of policy goals related to income security and employment. Many developed countries have achieved universal coverage through generalized social security schemes. For the developing countries, where many, if not the majority of persons, live at subsistence levels, income security is an issue of concern for all age groups. In several of these countries, the social security programs launched tend to offer limited coverage—in the rural areas, where in many cases most of the population lives, there is little or no coverage. Furthermore, particular attention should be paid, in social security and social programs, to the circum-

stances of the elderly women whose income is generally lower than men's and whose employment has often been broken up by maternity and family responsibilities. In the long term, policies should be directed toward providing social insurance for women in their own right.

Recommendation 36

Governments should take appropriate action to insure all older persons an appropriate minimum income, and should develop their economies to benefit all the population. To this end, they should:

(a) Create or develop social security schemes based on the principle of universal coverage for older people. Where this is not feasible, other approaches should be tried, such as payment of benefits in kind, or direct assistance to families and local cooperative institutions.

(b) Insure that the minimum benefits will be enough to meet the essential needs of the elderly and guarantee their independence. Whether or not social security payments are calculated taking into account previous income, efforts should be made to maintain their purchasing power. Ways should be explored to protect the savings of the elderly against the effects of inflation. In determining the age at which pensions are payable, due account should be taken of the age of retirement, changes in the national demographic structure, and of the national economic capacity. At the same time, efforts should be made to achieve continuous economic growth.

(c) In social security systems, make it possible for women as well as men to acquire their own rights.

(d) Within the social security system, and if necessary by other means, respond to the special needs of income security for older workers who are unemployed or those who are incapable of working.

(e) Other possibilities of making available supplementary retirement income and incentives to develop new means of personal savings for the elderly should be explored.

66. Broadly related to the issues of income security are the dual issues of the right to work and the right to retire. In most areas of the world, efforts by older persons to participate in work and economic activities which will satisfy their need to contribute to the life of the community and benefit society as a whole meet with difficulties. Age discrimination is prevalent—many older workers are unable to remain in the labor force or to reenter it because of age prejudice. In some countries this situation tends to impact women more severely. The integration of the aged into the machinery of development affects both the urban and rural population groups.

Recommendation 37

Governments should facilitate the participation of older persons in the economic life of the society. For that purpose:

(a) Appropriate measures should be taken, in collaboration with employers' and workers' organizations, to insure to the maximum extent possible that older workers can continue to work under satisfactory conditions and enjoy security of employment.

(b) Governments should eliminate discrimination in the labor market and insure equality of treatment in professional life. Negative stereotypes about older workers exist among some employers. Governments should take steps to educate employers and employment counselors about the capabilities of older workers, which remain quite high in most occupations. Older workers should also enjoy equal access to orientation, training, and placement facilities and services.

(c) Measures should be taken to assist older persons to find or return to independent employment by creating new employment possibilities and facilitating training or retraining. The right of older workers to employment should be based on ability to perform the work rather than chronological age.

(d) Despite the significant unemployment problems facing many nations, in particular with regard to young people, the retirement age for employees should not be lowered except on a voluntary basis.

Recommendation 38

Older workers, like all other workers, should enjoy satisfactory working conditions and environment. Where necessary, measures should be taken to prevent industrial and agricultural accidents and vocational diseases. Working conditions and the working environment, as well as the scheduling and organization of work, should take into account the characteristics of older workers.

Recommendation 39

Proper protection for workers, which permits better followup for people of advanced age, comes about through a better knowledge of occupational diseases. This necessarily entails training medical staff in occupational medicine.

Similarly, preretirement medical checks would allow the effects of occupational disease upon the individual to be detected and appropriate steps to be planned.

Recommendation 40

Governments should take or encourage measures that will insure a smooth and gradual transition from active working life to retirement, and in addition make the age of entitlement for a pension more flexible. Such measures would include preretirement courses and lightening the workload during the last years of working life, for example, by modifying the conditions of work and the working environment of the work organization, and by promoting a gradual reduction of work time.

Recommendation 41

Governments should apply internationally adopted standards concerning older workers, particularly those embodied in Recommendation 162 of the International Labor Organization. In addition, at the international level, approaches and guidelines concerning the special needs of these workers should continue to be developed.

Recommendation 42

In the light of ILO Convention No. 157 concerning maintenance of social security rights, measures should be taken, particularly through bilateral or multilateral conventions, to guarantee legitimate migrant workers full social coverage in the receiving country, as well as maintenance of social security rights acquired, especially regarding pensions, if they return to their country of origin. Similarly, migrant workers returning to their countries should be afforded special conditions facilitating their reintegration, particularly with regard to housing.

Recommendation 43

As far as possible, groups of refugees accepted by a country should include elderly persons as well as adults and children, and efforts should be made to keep family groups intact and to insure that appropriate housing and services are provided.

(f) Education

67. The scientific and technological revolutions of the 20th century have led to a knowledge and information "explosion." The continuing and expanding nature of these revolutions has given rise also to accelerated social change. In many of the world's societies, the elderly still serve as the transmitters of information, knowledge, tradition, and spiritual values; this important tradition should not be lost.

Recommendation 44

Educational programs featuring the elderly as the teachers and transmitters of knowledge, culture, and spiritual values should be developed.

68. In many instances, the knowledge explosion is resulting in information obsolescense with, in turn, implications of social obsolescense. These changes suggest that the eductional structures of society must be expended to respond to the educational needs of an entire lifespan. Such an approach to education would suggest the need for continuous adult education, including preparation for aging and the creative use of time. In addition, it is important that the aging, along with the other age groups, have access to basic literacy education, an well as to all education facilities available in the community.

Recommendation 45

As a basic human right, education must be made available without discrimination against the elderly. Educational policies should reflect the principles of the right to education of the aging, through the appropriate allocation of resources and in suitable education programs. Care should be taken to adapt educational methods to the capacities of the elderly, so that they may participate equitably in and profit from any education provided. The need for continuing adult education at all levels should be recognized and encouraged. Consideration should be given to the idea of university education for the elderly.

69. There is also a need to educate the general public with regard to the aging process. Such education must start at an early age in order that aging be fully understood as a natural process. The importance of the role of the mass media in this respect cannot be overstated.

Recommendation 46

A coordinated effort by the mass media should be undertaken to highlight the positive aspects of the aging process and of the aging themselves. This effort should cover, among other things:

(a) The present situation of the aged, in particular in rural areas of developed and developing countries, with a view to identifying and responding to their real needs.

(b) The effects of migration (both internal and international) on the relative aging of populations of rural areas, and its effects on agricultural production and living conditions in these areas.

(c) Methods to develop job opportunities for and adapt conditions of work to older workers. This would include developing or furnishing simple equipment and tools which would help those with limited physical strength to accomplish their assigned tasks.

(d) Surveys of the role of education and aging in various cultures and societies.

Recommendation 47

In accordance with the concept of lifelong education promulgated by the U.N. Educational, Scientific, and Cultural Organization (UNESCO), informal, community-based, and recreation-oriented programs for the aging should be promoted in order to help them develop a sense of self-reliance and community responsibility. Such programs should enjoy the support of national governments and international organizations.

Recommendation 48

Governments and international organizations should support programs aimed at providing the elderly with easier physical access to cultural institutions (museums, theaters, opera houses, concert halls, cinemas, etc.) in order to encourage their greater participation in leisure activities and the creative use of their time. Furthermore, cultural centers should be asked to organize for and with the elderly workshops in such fields as handicrafts, fine arts and music, where the elderly can play an active role both as audience and participants.

Recommendation 49

Governments and international organizations concerned with the problems of aging should initiate programs aimed at educating the general public with regard to the aging process and the aging. Such activities should start from early childhood and continue through all levels of the formal school system. The role and involvement of ministries of education in this respect should be strengthened in encouraging and facilitating the inclusion of aging in curricula, as an aspect of normal development and education for the life of individuals beginning with the youngest age, so leading to greater knowledge of the subject and to possible positive change in the stereotypical attitudes to aging of present generations. Nonformal channels and the mass media should also be used to develop such programs. The mass media should also be used as a means of promoting the participation of the aged in social, cultural, and educational activities within the community; conversely, the aged or their representatives should be involved in formulating and designing these activities.

Recommendation 50

Where stereotypes of the aging person exist, efforts by the media, educational institutions, governments, nongovernmental organizations, and the aging themselves should be devoted to overcoming the stereotyping of older persons as always manifesting physical and psychological disabilities, incapable of functioning independently, and having neither role nor status in society. These efforts are necessary for achieving an age-integrated society.

Recommendation 51

Comprehensive information on all aspects of their lives should be made available to the aging in a clear and understandable form.

(B) Promotion Policies and Programs

70. The full realization of the plan of action depends on the implementation of all international documents, strategies, and plans mentioned in paragraphs 4 and 5. In promoting policies and programs within the framework of the plan of action, CSDHA, UNFPA, UNDP, DTCD, and the regional commissions, as well as the specialized agencies, institutions, and other intergovernmental and nongovernmental organizations are urged to give maximum assistance to all countries at their request. Full use should also be made of opportunities existing for technical cooperation between developed and developing countries in the field of aging.

(1) Data collection and analysis

71. Data on the older sector of the population—collected through censuses, surveys, or vital statistics systems—are essential for the formulation, application, and evaluation of policies and programs for the elderly and for insuring their integration in the development process.

72. Governments and organizations that are in a position to do so should develop an information base which would be more specific than the "60-and-over" one now in use and which would be of help in planning the development of and solving problems concerning the elderly. The base could cover social, age, functional, and economic classifications, among others.

73. Household sample and other surveys and other sources of demographic and related socioeconomic statistics provide important data for use in formulating and implementing policies and programs for the elderly.

74. If they so request, all countries should be provided with the technical assistance needed to develop or improve data bases relating to their elderly and the services and institutions that concern them. The assistance should cover training and research in methodologies for collecting, processing, and analyzing.

Recommendation 52

Data on the aging could be developed along the lines of codification system which will give national governments information tabulated by sex, age groups, income levels, living arrangements, health status, and degree of self-care, among others. Such data could be collected through the census, micro or pilot census, or representative surveys. Governments are urged to allocate resources for that purpose.

Recommendation 53

Governments and institutions concerned should establish or improve existing information exchange facilities such as data banks in the filed of aging.

(2) Training and education

75. The dramatic increase in the number and proportion of older adults calls for a significant increase in training. A dual approach is needed: An international program for training concomitant with national and regional training programs that are particularly relevant to conditions in the countries and regions concerned. The needs of the elderly, as well as the implications of the aging of the population on development, need to be taken into account in developing education and training policies and programs for all ages, especially the younger generation.

Recommendation 54

Education and training programs should be interdisciplinary in nature, as aging and the aging of the population is a multidisciplinary issue. Education and training in the various aspects of aging and the aging of the population should not be restricted to high levels of specialization, but should be made available at all levels. Efforts should be made to regulate the training skills and educational requirements for different functions in the field of aging.

76. The exchange of skills, knowledge, and experience among countries with similar or comparable structures and composition, or having historical, cultural, linguistic, or other links, with respect to their aging population would be a particularly fertile area of international cooperation. Besides the transfer of specific skills and technologies, the exchange of experience regarding the wide array of practices relat-

ing to aging could also constitute an area for technical cooperation among developing countries. In regions which include both developed and developing countries side by side the rich opportunities for mutual learning and cooperation in training and research should be vigorously explored.

Recommendation 55

Intergovernmental and nongovernmental organizations should take the necessary measures to develop trained personnel in the field of aging, and should strengthen their efforts to disseminate information on aging, and particularly to the aging themselves.

Recommendation 56

Retirees' and elderly people's organizations should be involved in planning and carrying out such exchanges of information.

Recommendation 57

The implementation of several recommendations will require trained personnel in the field of aging. Practical training centers should be promoted and encouraged, where appropriate facilities already exist, to train such personnel, especially from developing countries, who would in their turn train others. These centers would also provide updating and refresher courses and act as a practical bridge between and among developed and developing regions—they would be linked with appropriate U.N. agencies and facilities.

Recommendation 58

At national, regional, and international levels, extra attention should be given to research and study undertaken in support of integrating the problems of aging in planning and policy formulation and management

Recommendation 59

Training in all aspects of gerontology and geriatrics should be encouraged and given due prominence at all levels in all educational programs. Governments and competent authorities are called upon to encourage new or existing institutions to pay special attention to appropriate training in gerontology and geriatrics.

(3) Research

77. The plan of action gives high priority to research related to developmental and humanitarian aspects of aging. Research activities are instrumental in formulating, evaluating and implementing policies and programs: (a) As to the implications of the aging of the population on development, and (b) as to the needs of the aging. Research on the social, economic, and health aspects of aging should be encouraged to achieve efficient uses of resources, improvement in social and health measures, including the prevention of functional decline, age-related disabilities, illness and poverty, and coordination of the services involved in the care of the aging.

The knowledge obtained by research provides scientific backing for a sounder basis for effective societal planning as well as for improving the well-being of the elderly. Further research is required, e.g., (a) to narrow the wide gaps in knowledge on aging and on the particular needs of the aging, and (b) to enable resources provided for the aging to be used more effectively. There should be emphasis on the continuum of research from the discovery of new knowledge to its vigorous and more rapid application and transfer of technological knowledge with due consideration of cultural and social diversity.

Recommendation 60

Research should be conducted into the developmental and humanitarian aspects of aging on local, national, regional, and global levels. Research should be encouraged particularly in the biological, mental, and social fields. Issues of basic and applied research of universal interest to all societies include:

(a) The role of genetic and environmental factors.

(b) The impact of biological, medical, cultural, societal, and behavioral factors on aging.

(c) The influence of economic and demographic factors (including migration) on societal planning.

(d) The use of skills, expertise, knowledge, and cultural potential of the aging.

(e) The postponement of negative functional consequences of aging.

(f) Health and social services for the aging as well as studies of coordinated programs.

(g) Training and education.

Such research should be generally planned and carried out by researchers closely acquainted with national and regional conditions, being granted the independence necessary for innovation and diffusion. States, intergovernmental organizations, and nongovernmental organizations should carry out more research and studies on the developmental and humanitarian aspects of aging, cooperate in this field and exchange their findings in order to provide a logical basis for policies related to aging in general.

Recommendation 61

States, intergovernmental organizations, and nongovernmental organizations should encourage the establishment of institutions specializing in the teaching of gerontology, geriatrics, and geriatric psychology in countries where such institutes do not exist.

Recommendation 62

International exchange and research cooperation as well as data collection should be promoted in all fields having a bearing on aging, in order to provide a rational basis for future social policies and action. Special emphasis should be placed on comparative and cross-cultural studies on aging. Interdisciplinary approaches should be stressed.

IV. RECOMMENDATIONS FOR IMPLEMENTATION

(A) Role of Governments

78. The success of this plan of action will depend largely on action undertaken by governments to create conditions and broad possibilities for full participation of the citizens, particularly the elderly. To this end, governments are urged to devote more attention to the question of aging and to utilize fully the support provided by intergovernmental and nongovernmental organizations including retirees' and elderly people's organizations.

79. Since wide divergencies exist with respect to the situation of the aging in various societies, cultures, and regions—as reflected in different needs and problems—each country should decide upon its own national strategy and identify its own targets and priorities within the plan. A clear commitment should be made at all levels of government to take appropriate action to implement those targets and priorities.

80. Governments can play an important role with regard to the plan of action by evaluating and assessing the aging process from the individual and demographic points of view, in order to determine the implications for development of these processes in the light of the prevailing political, social, cultural, religious, and economic situation.

81. The architects of national policies and strategies for the implementation of the plan of action should recognize that the aging are not a homogeneous group and be sensitive to the wide differences and needs of the aging at various stages of their lives. Governments should pay special attention to improving the lot of elderly women, who are often at a severe disadvantage.

82. The establishment of interdisciplinary and multisectoral machinery within governments can be an effective means of insuring that the question of the aging of the population is taken into account in national development planning, that the needs of the elderly are given the attention they merit, and that the elderly are fully integrated into society.

83. These actions will gain in effectiveness if their preparation, implementation and followup are well coordinated at various geopolitical levels. The coordination must flow from cooperation between those in positions of responsibility in all sectors and the representatives of pensioners and the aged, in order to insure the participation of the latter when decisions of direct concern to them are being taken. Hence, it would be appropriate to consider the setting up of corresponding planning, programing, and coordinating bodies at the national level.

84. In certain countries, some of the objectives of the plan of action have already been achieved; in others, they may only be accomplished progressively. Moreover, by their very nature, some measures will take longer to implement than others. Governments are urged, therefore, to establish short-, medium-, and long-term objectives

aimed at facilitating implementation of the plan, in the light of their resources and priorities.

85. Governments should, if necessary, retain in a suitable form (or encourage the formation of) the mechanisms established at the national level to prepare for the World Assembly on Aging, in order to be ready to facilitate in planning, implementing, and evaluating the activities recommended by the World Assembly.

(B) Role of International and Regional Cooperation

(1) Global action

86. International cooperation in implementation of the program of action on the establishment, inter alia, of a new international economic order and International Development Strategy for the Third United Nations Development Decade, based on the peaceful coexistence of states having different social systems, is essential to achieving the goals of the plan of action and can take the form of bilateral and multilateral cooperation between governments and by utilizing the U.N. system. Such cooperation could take the form of direct assistance (technical or financial), in response to national or regional requests, cooperative research, or the exchange of information and experience.

87. The General Assembly, the Economic and Social Council, and all its relevant subsidiary bodies, in particular the Commission for Social Development, the Governing Council of the U.N. Development Program (UNDP), and the legislative and policymaking bodies of the concerned specialized agencies and intergovernmental organizations are urged to give careful consideration to the plan of action and to insure an appropriate response to it.

88. In view of the role that the Center for Social Development and Humanitarian Affairs (CSDHA) of the Department of International Economic and Social Affairs has been playing within the U.N. system in matters related to the aging, it should be strengthened in order to continue to serve as the focal point for activities in that respect; to this end the Secretary General of the United Nations is requested, within the existing global resources of the United Nations, to give due consideration to the provision of appropriate increased resources for the implementation of the plan of action, which will be primarily at the national level.

89. The Administrative Committee on Coordination should consider the implications of the plan of action for the U.N. system with a view to continued liaison and coordination in implementing the provisions of the plan.

90. The need to develop new guidelines in areas of concern to the elderly should be kept constantly under review in relation to the implementation of the plan.

91. Governments, national and local nongovernmental voluntary organizations, and international nongovernmental organizations, are urged to join in the cooperative effort to accomplish the objectives of the plan. They should strengthen their activities by encouraging the formation of and utilizing regular channels of communication at the national level for consulting with the elderly on policies and programs that affect their lives. Governments are also urged to encourage and, where possible, support national and private organizations dealing with matters concerning the elderly and the aging of the population.

92. All States are invited to consider designating a national "Day for the Aging" in conformity with General Assembly Resolution 36/20 of November 9, 1981.

93. The International Plan of Action on Aging should be brought to the attention of the appropriate U.N. bodies responsible for preparations of the International Conference on Population (1984), so that its conclusions and recommendations could be taken into account in preparing the proposals to further implementation of the World Population Plan of Action.

(a) Technical cooperation

94. The United Nations, and in particular UNDP and the Department of Technical Cooperation for Development, together with the specialized agenies, should carry out technical cooperation activities in support of the objectives of the plan of action. CSDHA should continue to promote, and provide substantive support to, all such activities.

95. The voluntary trust fund for the World Assembly on Aging, established by General Assembly Resolution 35/129, should be used, as requested by the General Assembly, to meet the rapidly increasing needs of the aging in the developing countries, in particular in the least developed ones. The payment of voluntary public and private contributions should be encouraged. The trust fund should be administered by CSDHA.

96. Furthermore, as requested by the General Assembly in its Resolution 36/20, the fund should be used to encourage greater interest in the developing countries in

matters related to aging and to assist the governments of these countries, at their request, in formulating and implementing policies and programs for the elderly. It should also be used for technical cooperation and research related to the aging of populations and for promoting cooperation among developing countries in the exchange of the relevant information and technology.

97. Aging is a population issue which affects development and which requires increasing international assistance and cooperation and, therefore, the UNFPA is urged, in cooperation with all organizations responsible for international population assistance, to continue and to strengthen its assistance in that field, particularly in developing countries.

(b) Exchange of information and experience

98. The exchange of information and experience at the international level is an effective means of stimulating progress and encouraging the adoption of measures to respond to the economic and social implications of the aging of the population, and to meet the needs of older persons. Countries with different political, economic, and social systems and cultures and at different stages of development have benefited from the common knowledge of problems, difficulties, and achievements and from solutions worked out jointly.

99. Meetings and seminars have proved to be most valuable in providing a regional and international exchange of information and experience and should be continued. These could focus, inter alia, on promoting technical cooperation among developing countries and on monitoring the implementation of the plan of action.

100. CSDHA should coordinate the activities of regional and subregional research and development centers in the U.N. system, promote the preparation of information materials, as well as the constant exchange of information on problems and policies related to aging and the training of personnel, and facilitate activities related to technical cooperation among developing countries in collaboration with concerned governments and regions.

101. With respect to the exchange of information on matters concerning aging, it is essential that standardized definitions, terms, research methodologies be developed—the United Nations should treat these matters with all due importance.

102. The U.N. bodies concerned should encourage governments and the international community to pay special attention to developing programs, projects, and activities that will give older persons the skills, training, and opportunities necessary to improve their situation and enable them to participate fully and effectively in the total development effort. Special attention should be given to training courses in technologies that will enable older persons to continue to work in agriculture.

103. The International Plan of Action on Aging should be transmitted to the unit in the U.N. Secretariat responsible for International Youth Year (1985) in order that that unit may bring the recommendations and conclusions of the World Assembly on Aging—particularly as they relate to intergenerational matters—to the attention of national planning committees concerned with developing ideas for the Youth Year.

(c) Formulation and implementation of international guidelines

104. The appropriate organizations should undertake studies on and review periodically the effectiveness of existing international guidelines and instruments related to the subject of aging, in order to determine their adequacy in the light of changing conditions in the modern world and the experience gained since their adoption.

(2) Regional action

105. Effective implementation of the plan will also require action at the regional level. All institutions having regional mandates are therefore called upon to review the objectives of the plan and contribute to their implementation. In this respect, a central role should be played by the U.N. regional commissions.

106. In order to carry out the above-mentioned functions, government members of regional commissions should take steps to insure that their regular program of activities take into account the problems of aging.

107. Furthermore, in coordination with the conduct of the international review discussed above, the regional commissions should organize the periodic review of regional plans.

(c) Assessment, Review, and Appraisal

108. It is essential that assessment, evaluation, and review take place at the national level, at intervals to be determined by each country.

109. Regional appraisal and review should focus on the special role regional action can play and the particular advantages in can offer in such fields as training, research, and technical cooperation among developing countries.

110. It is recommended that the Commission for Social Development be designated the intergovernmental body to review the implementation of the plan of action every 4 years and to make proposals for updating the plan as considered necessary. The findings of this exercise should be transmitted through the Economic and Social Council to the General Assembly for consideration. To assist the Commission in its work it should be provided with periodic reports on progress made within the U.N. system in achieving the goals and objectives of the plan. CSDHA should serve as the coordinator of this process.

ITEM 11. DEPARTMENT OF TRANSPORTATION

DECEMBER 21, 1982.

DEAR MR. CHAIRMAN: I am pleased to forward to you the enclosed report which summarizes significant actions taken by this Department during 1982 to improve transportation facilities and services for older Americans. The report is being forwarded to you in response to your letter of November 9 to Secretary Lewis, requesting information for part 2 of the committee's annual report, Developments in Aging. Information will be submitted subsequently regarding relevant activities of the Urban Mass Transportation Administration.

If we can assist you further, please let us know.

Sincerely,

JUDITH T. CONNOR,
Assistant Secretary for Policy
and International Affairs.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during 1982 to improve transportation for elderly persons.[1] The information included in the report, which also includes measures being considered to extend the working life of commercial air carrier pilots, was furnished by the Office of the Secretary and by the following operating elements of the Department: Federal Aviation Administration (FAA), and Federal Highway Administration (FHWA). Information will be submitted subsequently regarding relevant actions of the Urban Mass Transportation Administration (UMTA).

REGULATIONS

Federal Aviation Administration

On July 8, 1982, FAA published in the Federal Register an advance notice of proposed rulemaking entitled "Flight Crewmembers; Limitations on Use of Services." The purpose was to solicit public comments to help in developing and implementing a program to gather data that might support a determination as to whether persons age 60 or older can safely serve as commercial air carrier pilots, i.e., pilots of airplanes operated under part 121 of the Federal aviation regulations. This action is partly in response to the concerns of many pilots who state the "age 60 rule" is discriminatory because it does not allow persons who fully meet the current medical standards for an appropriate medical certificate to serve as pilots in air carrier operations. It is also in response, in part, to the recommendations contained in the August 1981 report of the National Institute on Aging panel on the experienced pilots study. Also being considered is the possibility of establishing age limitations for flight engineers.

Federal Highway Administration

FHWA monitored the States' compliance with the Department's section 504 regulation requirement that existing safety rest area facilities on the Interstate Highway System be accessible to and usable by physically handicapped persons, including wheelchair users, by July 2, 1982. Virtually all such rest areas have been made accessible or are in the process of being made accessible. (In a few cases short-term waivers of the accessibility requirement have been granted to allow additional time for necessary construction work.)

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[1] Many of the activities highlighted in this report are directed toward the handicapped. However, more than one-third of the elderly are handicapped and will benefit from these activities.

FHWA also continued to monitor State compliance with section 402(b)(1)(f) of title 23, U.S.C., which requires curb cuts at newly constructed pedestrian crosswalks, and the FHWA requirement that all new pedestrian facilities on Federal-aid highways be designed to accommodate elderly and handicapped persons unless a waiver is granted. FHWA monitoring indicated that these requirements are being fully implemented.

CAPITAL ASSISTANCE

Federal Highway Administration

The section 18 program provided assistance for project administration, capital assistance, and operating assistance for public transportation service in nonurbanized areas. About $74 million was obligated for such activities in fiscal year 1982. This funding helped start new transportation systems and expanded others that directly benefited the elderly.

INFORMATION DISSEMINATION

Office of the Secretary (OST)

Because of continuing State and local government interest in accessible or specialized transportation services, the Department of Transportation technology sharing program has made available to State agencies copies of the following reports and other materials on transportation for elderly and handicapped persons:

—*Inflation-Responsive Transit Financing* describes innovative ways which have been used to fund public or special transportation services.

—*The Eurpoean Paratransit Experience* describes innovative approaches to providing services to elderly or handicapped persons, as well as the general public, as used in a variety of other countries.

—*Decision Procedures for Paratransit Market Selection and Service Evaluation* describes a new planning procedure which special transportation systems can use.

—*Planning for the Phase-in of Fixed Route Accessible Buses* sets forth a variety of techniques to use in planning services by wheelchair-lift equipped buses.

—*Vehicle Maintenance Practices Among 16(b)(2) Grantees,* prepared originally by Washington State DOT, covers a range of approaches to maintenance management in small or specialized systems.

Research materials were provided at a number of State-level transit meetings, including sessions in Idaho, Indiana, Kansas, Minnesota, North Carolina, Pennsylvania, Tennessee, Washington, and Wisconsin.

The Department, through FHWA, UMTA, and OST, continues its support of the six-States Transportation Accounting Consortium (TAC), which has as one of its missions the simplification of accounting and recordkeeping procedures for social service or coordinated transit systems. The consortium recently completed a detailed review of how these operators actually keep their books. This analysis is summarized in the report "Accounting and Reporting Procedures in Transportation: An Analysis in Six States."

TRAINING

Federal Highway Administation

Two training courses were conducted in fiscal year 1982 that included discussions of transportation problems of elderly and handicapped persons. There was a combined total of 18 presentations of these courses with approximately 375 attendees from Federal, State, and local transportation agencies. The courses were "Improving the Effectiveness of Public Meetings and Hearings" and "Social Considerations in Highway Project Development."

RESEARCH COMPLETED

Federal Highway Administration

A study entitled "Design Guidelines for Making Crossing Structures Accessible to the Physically Handicapped" was completed by the Georgia Institute of Technology's College of Architecture. This study produced a set of criteria for use by design engineers in making all major types of pedestrian crossing structures accessible to elderly and physically handicapped persons. Laboratory and field tests utilizing handicapped and nonhandicapped subjects provided information on the effects of ramp gradient and length, friction of surface materials, and surface detectability. This study also produced a user manual that will aid State and local planning and design engineers in making crossing structures accessible to a substantial proportion of elderly and physically handicapped individuals.

DEMONSTRATIONS

Federal Highway Administration

A study entitled "Development of Priority Accessible Network's is being implemented in Seattle, Wash., New Orleans, La., and Baltimore, Md. A design manual developed under a previous contract is being used to develop access routes between destinations frequently used by elderly and handicapped pedestrians. The routes will contain various features to guide, facilitate of otherwise aid this group of pedestrians.

URBAN MASS TRANSPORTATION ADMINISTRATION

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation, Urban Mass Transportation Administration (DOT/UMTA) during 1982 to improve transportation for elderly persons.

REGULATIONS

On July 20, 1981, the DOT issued an interim final rule and request for comment as amendments to the department's regulation concerning nondiscrimination on the basis of handicap in programs and activities receiving financial assistance from the Department of Transportation (504 regulation). This amendment effectively changed the requirement of the UMTA portion of the regulation from full accessibility to local option. Comments were received, evaluated and a notice of proposed rulemaking prepared. This notice is now being reviewed by the Office of Management and Budget and the Department of Justice.

POLICIES

A policy was issued which allows private, for-profit operators to participate in UMTA's 16(b)(2) program through lease arrangements with private nonprofit associations who are the recipients of these funds.

A statement of paratransit policy was issued which encourages paratransit services supplementing conventional mass transportation services. The policy encourages private participation in providing services such as special services to the elderly which are eligible for funding under various sections of the UMT Act.

INFORMATION DISSEMINATION

A contract was awarded to the International City Management Association and the National League of Cities to conduct executive seminars for mayors and city managers on cost effective ways of providing transportation for elderly and handicapped persons.

RESEARCH ONGOING

A study is underway on means to make greater use of the volunteer network in providing transportation to elderly and handicapped persons.

A number of cross cutting studies are underway which will take the results of a variety of demonstrations and attempt to define common findings among them. Relevant are "Coordination of Social Service Agency Transportation Services," "Travel Behavior of Elderly and Handicapped Individuals," "Impact of User-Side Subsidies on the Mobility of Elderly and Handicapped Persons" and "Transportation Brokerage."

Two grants were recently made (one to a State, and one to a major metropolitan area) to assist in purchasing a number of accessible paratransit vehicles which will be used in a variety of transportation services.

ITEM 12. DEPARTMENT OF THE TREASURY

DECEMBER 23, 1982.

DEAR MR. CHAIRMAN: I am pleased to submit the Treasury report for "Developments in Aging" on the Department's activities during 1982 which affected the aged. I hope our report will be of use to the Special Committee on Aging and others studying the problems faced by older Americans.

With best wishes.

Sincerely,

DONALD T. REGAN, *Secretary.*

Enclosure.

TREASURY ACTIVITIES IN 1982 AFFECTING THE AGED

The Treasury Department recognizes the importance and special concerns of older Americans, a group that will comprise an increasing proportion of the population in the decades ahead.

The Secretary of the Treasury is managing trustee of the social security trust funds. Treasury has been participating in the development of proposals to insure the financial integrity of social security both in the near and longer term.

The first condition for improving the financial well-being of social security is a strong economy. A strong economy provides a higher tax base, which eases the burden on workers who support social security and other types of transfer programs that benefit the elderly. The Treasury Department has been involved in the development and implementation of the President's economic recovery program to stimulate economic growth and reduce inflation. A healthy, growing economy also means stable prices which reduce uncertainty concerning the purchasing power that can be expected from assets and other forms of income relied upon by the elderly.

The agency of the Treasury with whom the greatest number of older Americans have contact is the Internal Revenue Service (IRS). Special activities of the IRS directed at helping persons age 65 and over are detailed in the next section. Activities of other Treasury agencies which affect older Americans are summarized in the last section of the report.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service places considerable emphasis on informing older Americans of their tax rights and responsibilities. IRS also continues to make special effort to inform these individuals who, because of immobility, impaired health, or other factors, may miss out on benefits to which they are entitled unless IRS reaches them directly.

IRS assistance to older Americans through the tax counseling for the elderly (TCE) program has been growing since the program's inception in 1980. Fiscal year 1982 was a particularly successful TCE year as the number of Federal income tax returns prepared by TCE volunteers increased by a dramatic 47 percent over those prepared in 1981. Many TCE volunteers also helped the elderly in preparing their State and local returns. In addition, volunteers helped elderly taxpayers in the computation of their estimated tax for the upcoming tax filing season.

In addition, IRS issued a number of informational materials targeted toward older Americans on the following topics:

—Single taxpayers age 65 and over are not required to file a Federal income tax return unless their income for the year was $4,300 or more (as contrasted with $3,300 or more for single taxpayers under age 65). Married taxpayers who could file a joint return are not required to file unless their joint income for the year was $6,400 or more if one of the spouses was 65 or over, or $7,400 or more if both were 65 or over. This is because all taxpayers age 65 or over get an extra personal exemption of $1,000. (See publication 554 for further information.)

—The special tax credit for the elderly enables persons 65 and over, and also persons under 65 who had pension or annuity income from a public retirement system, to reduce their taxes by as much as $375 if single, or $562.50 if married and filing a joint return. (See publication 524.)

—For houses sold after July 26, 1978, those age 55 and over are allowed a once-in-a-lifetime exclusion of up to $100,000 of gain on the sale. This exclusion was increased to $125,000 for houses sold after July 20, 1981. (See publication 523.)

—Some of the income received in retirement years is free from Federal income tax. This includes social security payments, railroad retirement benefits, payments from a general welfare fund, and payments for blindness. (See publication 525.)

—If both the taxpayer and his or her employer paid part of the cost of the taxpayer's pension or annuity, the taxpayer will not pay tax on the part of the pension or annuity that represents a return of cost. (See publications 567 and 575.)

—Prior to January 1, 1983, retirees with taxable pension income can avoid paying estimated tax or receiving a large tax bill at the end of the year by filing form W-4P authorizing the payer of the pension to withhold taxes from the pension payments.

—After December 31, 1982, the payers of pensions and annuities generally will withhold income tax from the payments unless the retiree notifies the payer that he or she does not want tax withheld. If the retiree previously filed form W-4P to have income tax withheld from periodic payments, the retiree may not have to file a new form W-4P if he or she wants to continue to have income tax withheld. The retiree should file a new form if he or she wants to increase or decrease the amount withheld. (See publication 505.)

—After June 30, 1983, payments of interest and dividends (including patronage dividends) generally will be subject to income tax withholding. An individual who is 65 or older whose tax liability for the preceding year was $1,500 or less for a couple, one or both of whom is 65 or older, who file a joint income tax return for the preceding year and whose tax liability was $2,500 or less, are exempt from withholding. (See publication 505.)

—Tax issues of particular interest to handicapped and disabled people are covered in publication 907.

All publications are available free of charge. They are also used extensively in taxpayer education programs, often in cooperation with organizations interested in the problems of retired persons.

IRS uses the print and broadcast media, specialized newsletters, and organizations serving older Americans to communicate tax information of interest to the elderly.

—To publicize the TCE program, in which nonprofit organizations provide free tax information and assistance to individuals age 60 and over, the IRS distributed a 12½ minute film entitled, "A Right Good Thing." The film, which describes tax situations frequently experienced by the elderly and depicts how the older taxpayer can get assistance at a local TCE site, is available free of charge to any interested group or organization.

—To further publicize TCE and other tax benefits for the elderly, one filing-season TV and three radio spots were produced as well as an illustrated drop-in ad for distribution to magazines. A taxpayer information materials (TIM) package containing two news releases, a newsletter item, and three live-copy radio spots is being prepared.

—One filmed television public service announcement (PSA) was produced and sent to each of the three major networks and approximately 1,000 television stations nationwide. Statistics from Broadcast Advertisers Reports, a firm which tracks the play of commercials and PSA's, indicate that these "Benefits for Older Americans" PSA's were used extensively.

—Three recorded radio PSA's (one in English, one in Spanish, and one with country music background) were sent to the major networks and to about 6,700 local radio stations. Live-copy radio materials provided to these outlets was also widely used.

—Materials for the print media were provided to newspapers, periodicals, and newsletters nationwide. Print materials were also sent to senior citizens and retirement organizations, such as the American Association of Retired Persons, National Council of Senior Citizens, National Retired Teachers Association, and to State offices which service the elderly. A newspaper supplement with an article directed toward older Americans was sent to 9,200 local newspapers.

The following are additional activities in which IRS engaged during calendar year 1982 which benefit elderly taxpayers.

—IRS continues its emphasis on securing ground floor space or, alternatively, easy access to elevators as an aid to elderly and handicapped taxpayers.

—During the year, IRS Inspection continued its efforts to warn senior citizens of the danger of being defrauded by "confidence" men impersonating IRS employees. Seven articles on the subject were published in newspapers and periodicals and several speeches were made to senior citizens groups. In 1982, three men were arrested by Internal Security Inspectors in separate incidents involving their attempts to defraud elderly persons. One of those men was sentenced to 6 years in prison.

REGULATIONS AND RULING ACTIVITIES

Notice 82-3, 1982-9 IRB 12, provides guidance regarding the amendments that should be made to qualified retirement plans (including subchapter S plans and Keogh plans), individual retirement accounts (IRA's) and simplified employee pensions (SEP's) in order to take advantage of the expanded opportunity for providing for retirement benefits that is afforded under the Economic Recovery Tax Act of 1981.

Notice 82-13, 1982-19 IRB 16, provides explanations and questions and answers relating to provisions of the Economic Recovery Tax Act of 1981 that increase benefits under retirement plans. The act eliminated restrictions that prevented many employees from contributing to an individual retirement account and permitted employees to make deductible voluntary contributions to qualified plans. The act also raised the limit on contributions that can be made to IRA's, Keogh's, and simplified employee pensions. The effect of this should be to increase amounts available on retirement.

Rev. Rul. 82-153, 1982-35 IRB 6, explains that although individuals who have attained age 70½ are not entitled to further deductions for contributions to an individual retirement account (IRA), they are not precluded from deferring tax on distributions from qualified retirement plans by rolling over the amount to an IRA. However, the minimum distribution provisions of section 408(a)(6) of the code require distribution of part of the rollover amount by the close of the year.

Notice 82-4, 1982-8 IRB 36, provides guidance to taxpayers regarding the portion of the joint and survivor annuity regulations under section 401(a)(11) of the code that were invalidated by the decision of the Tax Court in *B.B.S. Associates, Inc.*, 74 T.C. 1118 (1980). The notice advised taxpayers that changes in the regulations will permit qualified retirement plans to provide for the payment of a benefit to a participant other than in the form of a life annuity, unless the participant elects otherwise.

FORMS ACTIVITIES FOR THE ELDERLY

The inside front cover of the form 1040 package highlights several changes and important reminders for older taxpayers.

Taxpayers on social security and others who do not have to report taxable pensions may want to file the "short form" this year as the interest and dividend ceiling has been removed. They may now file form 1040A even if they had interest and dividend income over $400.

IRS has also made it easier to compute the tax. A single tax table now covers incomes up to $50,000 with the 10 percent tax reduction effective January 1, 1982, built into the table. The IRS will even compute the credit for the elderly for the taxpayer.

Form W-4P, which is used by retirees to withhold income tax from a pension or annuity, has been revised. The new form has a simplified and shortened worksheet which should save retirees a considerable amount of time in determining how much to have withheld.

OTHER TREASURY ACTIVITIES AFFECTING THE AGED

Other agencies of the Treasury also have an impact on the elderly as part of their specific functions. Developments during 1982 included:

—Treasury continued its expansion of the direct deposit program for Federal recurring payments. This program offers an added measure of convenience and security to many people, including retirees, who depend on regular Government checks by permitting direct deposits into a personal checking or savings account. The service was implemented in 1975 and now includes social security benefit, supplemental security income, civil service retirement, railroad retirement, Veterans Administration compensation and pension payments, and certain military active duty and retirement, and Federal salary payments. As of September 1982, over 17.2 million recipients have enrolled in the program, representing over 34.7 percent of total recipients. Since 1977, a nationwide educational campaign has been underway to inform recipients about the advantages of the program. Treasury's goal is to have 55 percent of all eligible recipients enrolled in the program by 1985 and 80 percent by 1990.

—The Bureau of Government Financial Operations has continued a longstanding record of reliably meeting issuance schedules for Government payments. The majority of these payments are to elderly beneficiaries who depend on receiving their payments on time each month. In fiscal year 1982, the Bureau issued over 700 million payments—about 80 percent involving social security benefits, railroad retirement, civil service retirement, veterans benefits, and supplemental security income. Coupled with programs such as direct deposit to insure reliable delivery after issuance, the Bureau is continuing efforts to improve service to recipients of Government payments.

—Millions of Americans have bought and held U.S. savings bonds over the past 40 years as a means of supplementing their retirement income. The tax-deferral and exchange privileges of these bonds have been particularly beneficial to retired individuals. In addition, the new variable rate feature, introduced on November 1, 1982, will enable bondowners to keep pace with market yields in times of high interest rates. Under the terms of the Treasury's new offering, the bonds will also be protected by a guaranteed minimum yield, should market rates decline substantially.

—During the development of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Office of Public Liaison and Consumer Affairs worked closely with representatives of retirees who were particularly concerned with exemptions for the elderly pertaining to dividend and interest withholding. Briefing materials on TEFRA were mailed. This office continued to work with the American Association of Retired Persons to encourage participation at meetings with the Internal Revenue Service when they were drafting temporary regulations for implementing provisions of TEFRA. Copies of these temporary regulations were made available to this group.

—The office of the Comptroller of the Currency has responsibility for enforcing the Equal Credit Opportunity Act and regulation B. The law and its implementing regulation prohibit a creditor from discriminating against an applicant on a prohibited basis regarding any aspect of a credit transaction. Prohibited basis includes age provided that the applicant has the capacity to enter into a binding contract. Enforcement of the law is carried out during regular examinations of national banks.

—The Treasury also continued to protect elderly recipients of Government payments through the vigilance of the Secret Service. During fiscal year 1981, the Service closed 28,585 social security check forgery cases and 10,450 supplemental security income forgery cases. Most of these checks were issued to retirees. Approximately 52 percent of the checks were cleared, that is, the identity of the forger was discovered.

Finally, the Department of the Treasury makes every attempt to participate in the governmentwide effort to end discrimination against particular groups, including the aged, in employment and in the accessibility of public information and facilities:

—Throughout the Department's facilities, architectural modifications and new buildings include ramps, security bars in restrooms, and other aids to insure that Treasury facilities are usable by all individuals.

—In employment, Treasury offices and bureaus have implemented a part-time employment program (PTEP) as a result of Public Law 93-437 (October 1978). The program gives special attention to groups such as older people. Although the opportunities for employment in general, including part time, are currently uncertain due to budgetary and staffing constraints, the PTEP has helped retirees and the elderly obtain meaningful employment. The employment of the elderly benefits both the individual, by supplementing his or her income, and the agency, by adding productive employees to the regular work force.

ITEM 13. ACTION

DECEMBER 14, 1982.

DEAR MR. CHAIRMAN: I am pleased to submit ACTION's annual report on programs and services for the elderly to the Special Committee on Aging.

Please do not hesitate to contact me if you have any questions.

Sincerely,

THOMAS W. PAUKEN, *Director.*

Enclosure.

OLDER AMERICAN VOLUNTEER PROGRAMS (OAVP)

Each of the older American volunteer programs provides opportunities for utilizing the resoucefulness, ingenuity, and skills of persons 60 years of age and over to provide services within their communities. Through their volunteer activities, they strengthen their own and the community's sense of worth by giving their time in the service of others.

There are no educational or experience requirements for enrollment: Participation in the foster grandparent program (FGP) and the senior companion program (SCP) is limited to persons whose income is not more than 125 percent of the poverty line established by the Economic Opportunity Act of 1964, as amended annually. They receive a stipend of $40 for a 20-hour week. The stipend is not considered income for tax purposes nor does it affect eligibility for other Federal or State programs. Retired senior volunteer program (RSVP) volunteers receive no stipen.

All volunteers serve under the sponsorship of local organizations. Categorical grants are awarded by ACTION to private nonprofit organizations and public agencies to recruit, train, place, and support volunteers. Day-to-day supervision is provided by volunteer stations which are public or private nonprofit agencies and organizations such as hospitals, day care centers, units of local governments, and community social service programs. Under certain circumstances, OAVP provides technical assistance to sponsors and training for project staff. Funding is shared between the sponsor and ACTION.

ACTION is committed to the principal that the satisfaction of each volunteer is a direct result of his or her involvement in activities which will improve the lives of others and enrich their own. OAVP seeks to:

(1) Encourage the recognition of the older person as a solution to problems rather than as a problem.

(2) Promote OAVP projects to develop program activities which include increasing the self-reliance of those served and mobilization of local resources to meet community needs.

(3) Coordinate OAVP program activities with other ACTION programs and with programs of other governmental and nongovernmental agencies.

(4) Encourage volunteer assignments in RSVP and FGP which increase intergenerational contacts.

(5) Encourage increased State and local funding of OAVP and OAVP-type projects.

The OAVP program concept has been greatly expanded by the use of State and local moneys to increase non-ACTION OAVP-type projects or to supplement existing ACTION projects. Some 41 State governments and many local governments are providing approximately $15 million for this purpose. These funds are in addition to the required local matching funds provided by all project sponsors. Since most State and local sponsors wish to be identified with one of the respective OAVP program titles, they have entered into written memoranda of understanding with ACTION. These memoranda allow the local projects to use the generic Federal program name and make the volunteers serving in these projects eligible under the income disregard provision of ACTION legislation with respect to foster grandparent and senior companion programs. Project staff participate in ACTION training activities, receive program assistance materials, and utilize the technical expertise of ACTION staff.

Volunteer total and funding for fiscal year 1982 was:

	Millions
RSVP (319,000 volunteers)	$26,388,000
FGP (18,100 volunteers)	46,079,000
SCP (5,280 volunteers)	12,170,000
Total	84,637,000

FOSTER GRANDPARENT PROGRAM

The foster grandparent program (FGP) was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare. It was given a legislative base in 1969 and transferred to the Administration on Aging in HEW. In July 1971, the program was transferred to ACTION.

FGP enables low-income persons, aged 60 or over, to remain active in their community through person-to-person service to children with special or exceptional needs in health, education, welfare, and related settings. Foster grandparents derive a renewed sense of dignity and self-worth from their special service roles.

In addition to a stipend of $2 per hour for a 20-hour week, they receive tangible benefits in the form of transportation to and from their volunteer station, a noon meal on the days they serve, accident and liability insurance, and an annual physical examination.

Children are assigned foster grandparents on the basis of their potential improvement in personal or social adjustments, skill development, and for deinstitutionalization. In the latter case, forster grandparents may follow deinstitutionalized children needing continuing attention to their own homes when possible and approved. Initial assignments of foster grandparents are also made in cases where they can have the greatest impact in the delay or prevention of institutionalization of children living in a home environment.

Foster grandparents give attention and affection to the children to whom they are assigned. Ideally, the volunteers spend 2 hours with each of two children on a daily basis. Some group settings are not appropriate for strict one-to-one assignments. In these cases, foster grandparents may serve several children as long as the setting is conducive to the volunteers and the children they serve. The program provides social, psychological, and educational benefits to children with developmental disabilities and related special needs. Foster grandparents simultaneously benefit from alleviation of some of the consequences of poverty and loneliness. Their psychological outlook and physical health are improved. The mutually benefiting relationship also has a notably positive effect on the children's development and the outlook of their families. The program provides a degree of human rights protection to both "grandparent" and "grandchild," insuring that each group is dealt with fairly and humanely.

Foster grandparents are provided orientation prior to assignment to individual children. Subsequently, they are provided monthly in-service training. They function as stipended volunteers and are not considered part of the regular work force. Their activities are limited to those which would not supplant the hiring of or result in the displacement of employed workers, or impair existing contracts for service. Foster grandparents may not provide physical therapy, babysitting service, housecleaning service, or other services normally performed by volunteer station staff to the children they serve. Foster grandparents are expected to accept supervision of volunteer station and project staff. Appropriate volunteer grievance and appeal procedures are the responsibility of the individual project sponsors.

Project staff are employees of the project sponsor; they are not employees of the Federal Government. ACTION requires concurrence in the selection of project directors.

The project director, on behalf of the sponsor, recruits, trains, and exercises general supervision over the volunteers. This person also develops memoranda of understanding with volunteer stations where volunteers are to be placed. He/she also insures that foster grandparents are assigned to children with demonstrated special or exceptional needs.

Project sponsors, in accepting ACTION grants to operate foster grandparent projects, agree to abide by agency regulations and policies. ACTION, in turn, provides training and technical assistance to sponsors and project staff, and promotes cooperation and coordination with other Federal, State, and local entities concerned with the needs of low-income elderly and children with special or exceptional needs, including transportation needs.

The foster grandparent program addresses the most pressing basic human needs both in seeking the poorest of the poor to serve as foster grandparents, and in the selection of individual children the volunteers serve.

During the entirety of fiscal year 1982, the program operated under authority of a continuing resolution at a level of $46.079 million. At year's end there were 18,100 funded foster grandparents serving approximately 54,000 children. There are 237 (federally funded) projects, with at least one project in each State, Puerto Rico, the Virgin Islands, and the District of Columbia. Additionally, more than 40 States now provide varying sums to expand foster grandparent opportunities and services. The State of Michigan also funds seven totally nonfederally funded projects, providing approximately 360 additional low-income elderly residents the opportunity to serve in and benefit from the program in addition to those serving in nine other projects receiving Federal funding.

RETIRED SENIOR VOLUNTEER PROGRAM

The retired senior volunteer program (RSVP) was established to provide a variety of opportunities for persons, aged 60 or over, to participate more fully in the life of their community through significant volunteer service. Through RSVP, over 300,000 older Amricans are making significant contributions toward solving some pressing problems of their communities. In turn, the program enables the elderly to find the dignity and usefulness they seek.

RSVP was originally authorized in 1969 and funded in 1971. In July 1971, it was transferred to ACTION. In 1981, RSVP celebrated its 10th anniversary. Over the last 10 years, several thousand communities all over the country have benefited from the efforts of RSVP volunteers.

RSVP is inherently a local community program. Each RSVP project is locally planned, operated, controlled, and supported. The non-Federal support of the budget is not required to be more than 10 percent during the first year. Project sponsors are expected to increase local support of the project budget by 10 percent each of the second and third years, assuming at least 30 percent financial responsibility each year thereafter.

A person 60 years of age or over is eligible to enroll in the program. There are no income, education, or experience requirements. Orientation, in-service training, and recognition are provided for the volunteers. Volunteers serve without compensation, but transportation assistance is provided between their homes and volunteer assignments when needed. Accident, personal liability, and, when appropriate, excess auto liability insurance are provided.

RSVP promotes older citizens as a resource capable of improving community life. They serve in hospitals, schools, courts, crisis centers, and other similar settings, assisting clients of all ages. They are involved in projects dealing with health care delivery, energy conservation, operation of food co-ops, and fixed income counseling.

RSVP volunteers have demonstrated an ability for making significant contributions to helping youth with problems. Services provided in the past year include counseling, especially in the area of alcohol and drug abuse; education, physical therapy to handicapped children; and skills/trade career development.

The Detroit, Mich., RSVP project has 14 volunteers assigned to the traveler's aid program at the Greyhound Bus depot and the Metropolitan Airport in Detroit. They provide counseling and referral services directing young runaways to half-way houses and social service agencies for immediate needs such as food and medical care.

Seven RSVP volunteers at Project Concern in Dubuque, Iowa, are serving at the Mercy Health Care Hospital with youthful alcohol and drug abusers. They assist the youth in occupational therapy workshops and act as listeners by encouraging the youths to discuss their problems.

With funding support and technical assistance provided by a cooperative private agency, 22 RSVP projects are placing volunteers to provide community support services to hardcore unemployable youths between the ages of 16 and 21.

In 1982, RSVP embarked on a cooperative demonstration effort with the senior companion program (SCP) in the provision of services in need of long-term care to remain in their own homes, and twc RSVP projects participated. These demonstration efforts examined various policy questions and tested specific variations in program models and volunteer service activities. In 1982, RSVP emphasized expansion in: (1) Services to youth; (2) inflation fighting; (3) long-term care, and (4) crime prevention. Since 1971, the retired senior volunteer program has experienced considerable growth. At the beginning of 1972, with a budget of $15 million, there were 34 RSVP projects and 1,816 RSVP volunteers. By the end of fiscal year 1982, with a budget of $26.3 million, there were 722 federally funded projects and over 300,000 RSVP volunteers participating nationwide.

There are RSVP projects currently operating in all 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

Older Americans are a national resource of tremendous worth. And as the need for volunteer services becomes even more pressing, the experience and ability of more than 300,000 RSVP volunteers will become increasingly valuable.

SENIOR COMPANION PROGRAM

The senior companion program (SCP) offers volunteer opportunities to adults age 60 and older who have annual incomes which fall below poverty guidelines. Senior companions provide personal assistance and companionship to primarily older audits in effort to support them in achieving their highest level of independent living.

The senior companion program has grown from 18 pilot projects and 1,000 senior companions in fiscal year 1974 to 80 projects and approximately 5.280 senior companions as of October 1, 1982. The operating budget in fiscal year 1982 was $12,170,000.

The program provides a visible demonstration that older persons can perform a critical role in contributing to the solution of problems that affect them. SCP fosters independence and enhances the self-esteem of the senior companions by engaging them in activities which improve the lives of individuals and communities.

SCP assists in long-term care needs of moderately and generally impaired adults, focusing on older adults whose physical, mental, and emotional impairments put them at risk of inappropriate or unnecessary institutionalization. Senior companions are placed at or through volunteer stations which are direct health care providers, social service agencies, and Federal and State long-term care networks.

In Scranton, Pa., 80 senior companions provide services to more than 400 frail elderly. The primary goals of this project are to facilitate discharge for acute care hospitals and prevent unnecessary readmissions. Senior companions meet patients prior to discharge and continue to serve them during the crucial transition period to their own homes. The hospital administration has observed that many patients have been discharged who otherwise would have remained in the hospital because of social problems.

One example is the story of Ben, an 87-year-old stroke victim in upstate New York. The hospital social services unit had recommended Ben's discharge to a nursing home. Ben's wife wanted him home, but the discharge planning staff felt that she was too frail to care for him. Then 79-year-old senior companion Allen Gadensky was assigned to help Ben regain his self-confidence and take an active interest in his physical therapy.

Gadensky's encouragement was so successful that the care plan assessment team reappraised the situation and agreed to send Ben home on the condition that Gadensky continue to provide supportive services and monitor Ben's progress for the hospital.

After 9 months, Ben now takes short walks on his own. Reality orientation exercises, building on positive lifelong experiences and other efforts to rekindle an interest in his surroundings have enabled him to remain in his own home—thanks to Gadensky's attention and care.

Prevention of substance abuse among the elderly is another of the programmatic goals of the senior companion program. ACTION has provided information and training to all senior companion project directors in this area and the project directors in turn have been training the volunteers. We have focused on the misuse and abuse of prescription drugs, over-the-counter drugs, and alcohol. Many of the volunteers who are serving in this area were former abusers themselves.

Approximately 80 percent of the senior companions are assigned to assist older persons to remain in their own places of residence.

The senior companions assist clients in patient-release programs in acute care hospitals, mental health, and other long-term care facilities to make the transition and adjustment of living in less restrictive settings.

In all placements, the senior companions serve as advocates by linking clients to appropriate services and assuring that they receive benefits for which they are entitled.

Senior companions receive a stipend of $40 a week for 20 hours of service. They are also provided or reimbursed for transportation and meals for days of service, orientation, or training. Volunteers are covered by accident and liability insurance and receive annual physical examinations. Senior companions are also provided an orientation and regularly scheduled in-service training.

ITEM 14. COMMISSION ON CIVIL RIGHTS

DECEMBER 13, 1982.

DEAR MR. CHAIRMAN: The U.S. Commission on Civil Rights is pleased to respond your request for a statement concerning our fiscal year 1982 activities affecting the interests of older persons.

The U.S. Commission on Civil Rights is an independent Federal agency established by Congress in 1957 to study and collect information on discrimination and denial of equal protection of the laws, to appraise the laws and policies of the Federal Government, to serve as a national clearinghouse for information on civil rights, and to report to the President and Congress. The Commission's jurisdiction covers matters involving discrimination based on race, color, religion, sex, national origin, age, handicap, and the administration of justice.

During fiscal year 1982, the Commission continued to monitor legislative, legal, and regulatory developments affecting Federal enforcement of prohibitions against age discrimination. The main focus of attention continued to be the Equal Employment Opportunity Commission's (EEOC) enforcement of the Age Discrimination in Employment Act (ADEA) 0f 1967, as amended. In a March 1982 letter to EEOC, the Commission called for, among other things, more concise interpretative guidance under the ADEA and reiterated our concern that EEOC's ADEA interpretations permit age bias in *bona fide* apprenticeship programs. Commission staff provided technical comments to EEOC on a proposed management directive that prescribed the application of theories of discrimination under ADEA and also title VII of the Civil Rights Act of 1964 to the analysis of complaints of job discrimination in the Federal sector. Further, in the chapter on EEOC in the June 1982 Commission report, "The Federal Civil Rights Enforcement Budget: Fiscal Year 1983," the Commission warned that budget and staff reductions at EEOC might increase the processing time for age discrimination complaints from 7½ to 8½ months, despite improved processing procedures.

As reported last year, the Commission also continued to participate in the work of the interagency advisory work group on the Department of Health and Human Services' evaluation of Federal Mediation and Conciliation Service mediation of age discrimination complaints, pursuant to the Age Discrimination Act.

Pursuant to the congressional mandate of the Older Americans Act (Public Law 95-478), as amended, the U.S. Commission on Civil Rights undertook a study of racial and ethnic discrimination in federally assisted programs for older persons. The study was conducted in two phases, covering minority employment, receipt of contracts and grants, and participation in service programs. Through indepth examination of operations of programs funded under title III of the Older Americans Act, the Commission sought to assess: (1) Whether and in what capacities minorities are employed under Older Americans Act programs; (2) whether and to what extent minority firms and organizations are awarded contracts and grants under the programs; and (3) whether and to what extent older minorities receive the services provided by these programs. The results of the two-phase study were published in a two-part report.

The Commission issued an executive summary of part I of the report for distribution at the 1981 White House Conference on Aging. The Commission published part I of the two-part study on racial and ethnic discrimination in federally assisted programs for older Americans in June 1982. Titled "Minority Elderly Services: New Programs, Old Problems—Part I, the study examined minority elderly participation in title III, Older Americans Act programs administered by the Administration on Aging in six communities across the Nation. As we reported last year, the six cities selected for the study were Bridgeport, Conn.; Cleveland, Ohio; Honolulu, Hawaii; San Francisco, Calif.; Tucson, Ariz.; and Tulsa, Okla. They were selected to include geographically diverse sites having substantial representation of American Indians, Asian and Pacific Island Americans, blacks and Hispanics. The 180-page report reported the virtual absence of minorities in decisionmaking positions among area agency on aging staff, low representation of minority firms and organizations among area agency contractors, and underrepresentation of older minorities as program participants. It concluded that area agencies on aging were not actively involved in outreach activities to include more minorities in their programs.

The Commission also completed work on part II of the report which contains the results of a national survey of State and area agency and interviews at the Administration on Aging. Part II also covered minority experiences in connection with employment, grants/contracts, and service delivery of Older Americans Act programs. The national data in part II, which is scheduled for release in January 1983, confirmed the findings of part I. The data collected in both phases of the Commission's report reveal that the policies and practices generally followed by Administration on Aging officials, State units on aging, area agencies on aging, and their service providers adversely affect minority participation in Older Americans Act programs. The Commission concluded that despite the fact that minorities can be found among program participants as employees, grantees, and service recipients, full participation by minorities is a right yet to be realized.

Finally, the Commission continues to respond to requests for information on aging and the 51 State advisory committees to the Commission continue to monitor activities affecting the interests of older persons. In research projects and investigations, the Commission continues to take steps to include, where feasible, concerns related to the Commission's age jurisdiction.

If the Commission can be of any further assistance to the Special Committee on Aging, do not hesitate to contact me at 254-8130.

Sincerely,

JOHN HOPE III,
Acting Staff Director.

ITEM 15. COMPTROLLER GENERAL OF THE UNITED STATES (GENERAL ACCOUNTING OFFICE)

DECEMBER 17, 1982.

DEAR MR. CHAIRMAN: In response to your November 9, 1982, request for information concerning programs and services for the elderly, we are enclosing a statement of our internal activities which involve the elderly enclosure I). We have also included a list of reports issued during the period September 30, 1981, through September 30, 1982 (enclosure II), and a list of current assignments (enclosure III) which relate to programs and services for the elderly.

Copies of the issued reports are being provided to your office separately. A summary of the major findings and conclusions for each report is included in a digest bound in each report or in the letter transmitting it.

Sincerely yours,

PHILIP A. BERNSTEIN, *Director.*

Enclosures.

ENCLOSURE I.—*General Accounting Office's Internal Activities Which Involve the Elderly*

In continuing our policy regarding employment of the elderly, during the period from October 15, 1981, through December 9, 1982, GAO has appointed 453 persons to permanent and temporary positions. Of that number, 27 persons were age 40 and older at the time of their appointment.

As of December 9, 1982, 1,802 persons age 40 and older (34 percent of our work force) were on the rolls of GAO. Although employees in this age group participate widely in all our programs, we especially note that we have had five employees age 40 and older in the upward mobility program. This program usually draws participants from a younger population.

Equal employment opportunity and merit promotion, two programs covered by GAO orders, provide the basis for our policy regarding employment of the elderly. Other policies and practices evolved from the prohibition of discrimination on the basis of age in employment and in selection for job vacancies. For instance, because training is important to enhance effectiveness and provide opportunities for advancement, older employees are included in opportunity for training, both inhouse and outside the agency.

The employee health maintenance examination, a comprehensive and professional medical examination, is available on a 2-year cycle for all employees age 40 and older. Employees nearing retirement age have available individual preretirement counseling. The Office of Organization and Human Development provides semiannual preretirement seminars. Our Civil Rights Office also provides information and advice to persons regarding complaints of alleged discrimination because of age.

ENCLOSURE II.—*General Accounting Office elderly related reports issued during the period September 30, 1981 through September 30, 1982*

Title of report	*Date*
State Field Offices Are Not Protecting Social Security Beneficiary Information From Potential Abuse and/or Misuse (HRD-81-151) Sept. 30, 1981.	Sept. 30, 1981.
Procedures To Safeguard Social Security Beneficiary Records Can Still Be Improved (HRD-81-157).	Oct. 19, 1981.
Better Management of Private Pension Plan Data Can Reduce Costs and Improve ERISA Administration (HRD-82-12) Oct. 19, 1981.	
Medicaid's Quality Control System Is Not Realizing Its Full Potential (HRD-82-6).	Oct. 23, 1981.
Age Discrimination and Other Equal Employment Opportunity Issues in the Federal Work Force (FPCD-82-6).	Nov. 20, 1981
Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare (HRD-82-17).	Dec. 1, 1981.

ENCLOSURE II.—*General Accounting Office elderly related reports issued during the period September 30, 1981 through September 30, 1982*—Continued

Title of report	*Date*
Solving Social Security's Computer Problems: Comprehensive Corrective Action Plan and Better Management Needed (HRD-82-19).	Dec. 10, 1981.
Guidance and Information Needed on the Use of Machine Readable Claims Under Medicare and Medicaid (HRD-82-30).	Dec. 16, 1981.
Information on Medicare's Hospital Inpatient Routine Operating Cost Reimbursement Limits for Duluth-Superior (HRD-82-23 and 24).	Dec. 22, 1981.
How Health Maintenance Organizations Control Costs (HRD-82-31).	Dec. 29, 1981.
Social Security Needs To Determine the Cost Effectiveness of Manually Identifying Supplemental Security Income Recipients With Income From Other Federal Sources (HRD-82-33).	Jan. 8, 1982.
Legislative and Administrative Changes To Improve Verification of Welfare Recipients' Income and Assets Could Save Hundreds of Millions (HRD-82-9).	Jan. 14, 1982.
Do Aged Medicare Patients Receive More Costly Routine Nursing Services? Evidence Inconclusive (HRD-82-32).	Jan. 20, 1982.
Physician Cost-Containment Training Can Reduce Medical Costs (HRD-82-36).	Feb. 4, 1982.
Medicare Equalization Factor Payments To Group Practice Prepayment Plans Should Be Stopped (HRD-82-39).	Feb. 18, 1982.
Analysis of Four States' Administration of the AFDC Program: Management Improving But More Needs To be Done (HRD-82-20).	Feb. 22, 1982.
Information on Selected Medicare Independent Dialysis Facility Audits (HRD-82-42).	Feb. 22, 1982.
Legislation Is Needed To Ensure That Cost-of-Living Increases In Federal Programs Will Be Considered on a More Timely Basis in Computing Supplemental Security Income Benefits (HRD-82-52).	Mar. 26, 1982.
The Residential Conservation Service: Issues Affecting the Program's Future (EMD-82-70).	Mar. 29, 1982
Status of Special Efforts to Meet Transportation Needs of the Elderly and Handicapped (CED-82-66).	Apr. 15, 1982.
Information on Programs Involved in the President's Swap Proposal (CED-82-71).	Apr. 15, 1982.
Need To Establish Standards That Must Be Met Before Intermediate Care Facilities for the Mentally Retarded Can Obtain Medical Reimbursement (HRD-82-57).	Apr. 16, 1982.
Inquiry About Alleged Discriminatory Medicare Part B Reimbursement in New Jersey (HRD-82-58).	Apr. 19, 1982
Identifying Computer Data Bases To Aid Congressional Oversight on the Needs of Older Americans (IPE-82-6).	Apr. 19, 1982.
Discontinuing Social Security's Currently Insured Benefit Provision Would Save Millions and Eliminate Inequities (HRD-82-51)..	Apr. 23, 1982.
Investigation To Reform Teamsters' Central States Pension Fund Found Inadequate (HRD-82-13).	Apr. 28, 1982.
Complete and Accurate Information Needed In Social Security's Automated Name and Number Files (HRD-82-18).	Apr. 28, 1982.
Need To Recover Medicare Part B Duplicate Payments in Illinois (HRD-82-67).	Apr. 30, 1982.
The Status of the Department of Health and Human Services' Compliance with Requirements To Establish a Data Collection Plan for the Medicaid Home and Community Care Waiver (IPE-82-3).	May 4, 1982. May 10, 1982.
Information on Prospective Reimbursement Systems (HRD-82-73).	
Rural Health Clinic Services Act Has Not Met Expectations (HRD-82-62).	May 14, 1982.
Federal Efforts To Simplify the Aid to Families with Dependent Children, Medicaid, and Food Stamp Program Requirements and Quality Control Procedures (HRD-82-78).	May 18, 1982.
Delays in Processing Medicare Beneficiary Claims in Texas (HRD-82-74).	May 19, 1982.
Examination of the Social Security Administration's Systems Modernization Plan (HRD-82-83).	May 28, 1982.
A CPI for Retirees Is Not Needed Now But Could Be in the Future (GGD-82-41).	June 1, 1982.

Enclosure II.—*General Accounting Office elderly related reports issued during the period September 30, 1981 through September 30, 1982*—Continued

Title of report	*Date*
Results of Investigation Into Alleged Quotas Being Used by the Social Security Administration To Terminate Disability Insurance Benefits (HRD-82-88).	June 3, 1982.
Social Security Benefit Increase for Inflation May Leave Many Retirees Worse Off Financially (HRD-82-40).	July 2, 1982.
Relationship of Dual Benefit Windfall Payments to Total Railroad Retirement Benefits (HRD-82-97).	July 12, 1982.
State Drawdowns and Use of Low-Income Home Energy Assistance Program Funds (HRD-82-100).	July 12, 1982.
Preliminary Findings on Patient Characteristics and State Medicaid Expenditures For Nursing Home Care (IPE-82-4).	July 15, 1982.
Waiver of Medicaid Freedom-of-Choice Requirement: Potential Savings and Practical Problems (HRD-82-90).	July 20, 1982.
Medicare Payments for Durable Medical Equipment Are Higher Than Necessary (HRD-82-61).	July 23, 1982.
Federal Oversight of State Medicaid Management Information Systems Could Be Further Improved (HRD-82-99).	July 30, 1982.
Impact of Medicare Reimbursement Limits on Small Rural Hospitals (HRD-82-109).	Aug. 6, 1982.
Assessment of the Use of Tax Credits for Families Who Provide Health Care to Disabled Elderly Relatives (IPE-82-7).	Aug. 27, 1982.
Responses to Questions About Performance Evaluation Criteria for Professional Standards Review Organizations (HRD-82-124).	Sept. 2, 1982.
Social Security Needs To Determine the Cost Effectivenes of the Supplemental Security Income Redetermination Process and To Implement Recommendations Made for Eliminating Erroneous Payment (HRD-82-126).	Sept. 2, 1982.
The Elderly Remain in Need of Mental Health Services (HRD-82-112).	Sept. 16, 1982.
A Primer on Competitive Strategies for Containing Health Care Costs (HRD-82-92).	Sept. 24, 1982.
VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes (HRD-82-114).	Sept. 30, 1982.

Enclosure III.—*General Accounting Office audits in process which concern the elderly*

Review of Governmentwide Discrimination Complaint Processes.[1]

Medicaid Reimbursement and Nursing Home Bed Supply: An Analysis of Multiyear Survey Data.[1]

Review of Hurricane Emergency Plans.[1]

Potential Savings From Chicago in Eligibility for Beneficiaries of Medicare and Federal Employee Health Benefits by Making the Federal Employee Health Benefit Program the Primary Payor.

Survey of Medicare Reimbursement Differential for General Practitioners and Specialists.

Survey of Physician Reimbursement in the End Stage Renal Disease Program.

Survey of Related Organizations Principals of Management.

Reviews of Medicare/Medicaid Reimbursement for Indian Health Care Clinics.

Review of Utilization Review Efforts for Respiratory/Inhalation Therapy.

Survey of Medicaid Reimbursement Systems for Nursing Homes.

Survey of Cost Increases Resulting From Purchases of Hospital Assets.[1]

Survey of Utilization Review Efforts for Intensive Care Units.

Survey of State Medicaid Audit of Nursing Homes.

Survey of Medicare/Medicaid Controls Over Payments for Prosthetic Lenses.

Survey of Carrier Controls Over Medicare Part B Duplicate Payments.

Review of Current Medicare Requirements for Controlling Payments by Medicare Providers for Service Contracts.[1]

Survey of Purchasing Arrangements Under Hospital Full-Service Management Contracts.[1]

Survey of the Cost of Cardiac Pacemakers and Related Services Under Medicare.[1]

Survey of Third-Party Liability for Medicare/Medicaid Crossover Claims.

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[1] Being performed at the request of committees or individual Members of Congress.

Review of the 1981 White House Conference on Aging.[1]

Survey of ACTION'S Current Program Policies and Management Practices.[1]

Review of Recovery Techniques Used in Public Assistance Programs.

Review of Railraod Retirement Board's Awards of Disability Claims.[1]

Review of Social Security Administration's Actuarial Projections.

Review of Parent Benefits or Spouses with Older Children.

Survey of Social Security's Earnings Records for the Self-Employed.[1]

Survey of Social Security Administration's Payments to Beneficiaries Living Overseas.[1]

Survey of Social Security Administration's Program for Detecting Unreported Changes in the RSDI Program.

Survey of Social Security Administration's Annual Reporting Requirements and Earnings Enforcement.[1]

Survey of Early Retirees' Dependents Benefits.

Survey of Potential Income Enforcing Interest and Penalty Provisions.

Review of Social Security Administration's Short-Term Windfall Benefits.[1]

Nonprofit Groups Withdrawing From Social Security.[1]

Survey of Social Security Administration's Processes for Resolving Self-Employed Earnings Postings.

Review of Benefit Recomputation Due to Late Earnings Postings.[1]

Survey To Determine if Social Security Disability Benefits Are Offset by Federal Workers' Compensation Payments As Required by Law.

Survey of Relationships Between Worker's Compensation and Social Security Administration's Disability Program.

Survey of Social Security Administration's Potential To Return Disabled to Work.

Survey of the Cost Effectiveness of the Current Legislative Periodic Review Requirements for Social Security's Disability Programs.

Survey of the Use of Consultative Examinations in the Social Security Disability Program.

Medical Improvement Standard for Continuing Disability Investigations.

SSA's Determination of Mental Disabilities.

Review of Employment Agency Compliance with the Age Discrimination in Employment Act.[1]

Survey of VA's Health Care Planning for Aging Veterans.

Review of Assumptions of Private Pension Liability Under ERISA.

Review of Multiemployer Pension Plan Amendments Act's Effects on Parties Associated with Selected Plans.[1]

Survey of the General Rules for Employers' Multiemployer Pension Plan Withdrawal Liability.[1]

Survey of the Actuary's Role in Administering Multiemployer Pension Plan.[1]

Survey of the Effects on Employers and Participants of Reducing Unfunded Plan Liabilities and Converting Defined Benefits to Defined Contributions Plans.[1]

Survey of Labor's Investigations of Allegations of Abuse of Trust Funds Involving the Southern Nevada Culinary Workers and Bartenders Pension Trust.[1]

Review of Labor's Solicitor Office's Handling of Complaints on ERISA and Non-ERISA Union Corruption.[1]

Review of Labor's Handling of Allegations of Corruption Involving Labor Unions and Their Pension Funds From January 1976 to Present.[1]

Evaluation of Distribution of Terminated Pension Plan Assets.[1]

Review of Internal Controls in Social Security Administration's Title II Computerized Systems.[1]

Review of Social Security Administration's Problems in Implementing New Program Legislation.[1]

Survey of Medicare Automated Payment System.

Feasibility Study For Transferring St. Elizabeth's Hospital to the District of Columbia.[1]

Survey of Special Industry Rules for Employers' Multiemployer Pension Plan Withdrawal Liability.[1]

Survey of Reorganization Provision of the Multiemployer Pension Plan Amendments Act.[1]

ITEM 16. ENVIRONMENTAL PROTECTION AGENCY

JANUARY 21, 1983.

DEAR MR. CHAIRMAN: Thank you for your letter of November 9, 1982, requesting information concerning opportunities for the elderly. I am pleased to inform you of the continuing services and expanded activities of the Senior Environmental Employment (SEE) Corps.

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[1] Being performed at the request of Committees or individual Members of Congress.

The Corps has provided meaningful part-time employment to several hundred older Americans in jobs relating to the prevention, abatement, and control of environmental pollution. The jobs include surveying toxic chemicals used in industrial areas, educating the public on areawide water quality planning, establishing and enforcing noise abatement control programs, establishing and managing Agency environmental libraries, presenting education programs on the use of pesticides and the hazards of poisoning to farm workers, and working on surveys of environmental carcinogens.

For example, our Office of Monitoring Systems and Quality Assurance was able to use older workers to supplement their administrative staff during crisis situations, such as our investigation of Three Mile Island. Under the SEE Corps, qualified workers can be recruited on short notice to assist in similar situations.

In addition, the Office of Noise Abatement and Control developed a cadre of senior citizens to combat noise pollution. Volunteers serve as noise counselors in 50 or more communities throughout the country giving technical assistance to State and local communities or assisting in noise surveys and public education.

EPA also has a SEE Corps group whose responsibility is working with the States in training school personnel on what to look for and how to test for asbestos contamination in public schools. This program is being expanded to include all schools and public buildings.

Yet another SEE Corps program deals with solid and hazardous waste disposal methods. The senior citizens work with Federal, State, and local governments, and civic organizations to establish proper disposal procedures for the waste.

EPA has supported other activities of title V, including older worker programs in Florida, Alabama, California, Iowa, and Washington. In addition, the Agency has helped to support a poison alert project staffed by older workers in the States of California, Washington, and Iowa. Other States conducted noise surveys and studies, and in the State of Washington, older workers are monitoring landfills to measure the gases seeping from underground to the surface.

For the past several years, the Congress has sponsored a bipartisan program designed to acquaint selected senior citizens with the working of the legislative branch. This program, called the congressional senior citizen intern program, has historically included information sessions with several executive branch agencies who have programs on aging. As a result of the success of the SEE Corps, EPA was asked to participate in the program. The program provided EPA with an excellent opportunity to acquaint the 350 or so distinguished older Americans with the history, objectives, and goals of the Agency, as well as the opportunities that the SEE Corps can afford them and their fellow senior citizens.

EPA has recruited and trained a nucleus of senior citizens throughout the country to do surveying, whom we can call on from time to time to generate pesticide usage data. This allows EPA to establish statistically valid information which will permit States to monitor the kinds and amounts of pesticides being applied, and aggregate State data on pesticides.

Also, as a result of the success of the SEE Corps, EPA and its State counterparts are making efforts to expand the program. To help publicize the SEE Corps, we developed a short film entitled, "SEE—It's Working." It relates how the States have benefited from the talents and skills of older workers and the way SEE Corps members feel about their participation in the programs and the work they are doing.

We believe that the SEE Corps provides excellent opportunities for older citizens to participate in the benefit from the program while improving environmental quality for everyone.

Sincerely yours,

ANNE M. GORSUCH, *Administrator.*

ITEM 17. FEDERAL COMMUNICATIONS COMMISSION

DECEMBER 13, 1982.

DEAR MR. CHAIRMAN: This is in response to your letter of November 9, 1982, requesting fiscal year 1982 information regarding initiatives or programs by this Commission that impact either directly or indirectly on the elderly.

While the Federal Communications Commission does not focus solely on the needs of the elderly, certain of its actions indirectly affect this important segment of the population.

During the past several years, the Commission has participated in legislation and rulemaking designed specifically to help the handicapped, categories of which include the deaf and hearing impaired, blind and physically disabled. Since a significant proportion of people age 65 or older falls into these categories, consideration of telecommunications needs of the handicapped is a matter of interest to the elderly community, although perhaps not specifically directed to the elderly.

The FCC fiscal year 1981 report on this subject discussed several of these rulemakings. Among those efforts completed during fiscal year 1981 were provision of closed captioning television for the deaf and adoption of a rule allocating frequencies for operation of tactile paging devices for the deaf, blind, or physically handicapped. Additionally, last year's notice of proposed rulemaking to provide teletext data transmission service is progressing. Teletext provides home shopping services, news and weather, as well as enhanced closed captioning of regular television programs. Closed captioning is now available to some extent on line 21 of the television screen.

Also, AT&T filed tariffs last year with the FCC for an all-day rate reduction for hearing-impaired individuals using the teletypewriter for the deaf. The FCC subsequently approved this reduction.

Efforts to aid the disabled continued in fiscal year 1982. One proceeding with implications for the aging involved petitions for waiver of FCC rules under the *Second Computer Inquiry*. The waiver permits local telephone companies to continue to provide customer premises equipment (CPE) to meet the special needs of the elderly, beyond January 1, 1983.

Absent such a waiver, Bell operating companies (BOC's) would be prohibited from providing new pieces of such equipment after that date since the Bell system has decided that all new CPE will be provided under the Commission's detariffing and structural separation requirements by a new subsidiary of AT&T rather than by separate subsidiaries of each BOC. The pleading cycles on these petitions were completed on December 1, 1982, and the Commission is expected to issue a decision before the end of 1982.

A number of FM radio stations offer reading services for the blind. These services are provided via a special technology termed "SCA" which was authorized by the Commission in the past. A notice of proposed rulemaking issued by the Commission earlier this year proposes to create an additional SCA on each station, which could expand the allowed uses of SCA's and could permit the addition of new services of value to the elderly.

On July 23, 1982, the Commission acted to expand the scope of use for auditory assistance devices for the hearing-impaired. These devices project a speaker's voice to a transmitter near the handicapped person. They are permitted to be used in areas outside of educational institutions, to which they previously had been restricted. Their use in such places as churches, theaters, and private homes enriches the quality of life for many elderly.

A major piece of legislation concerning the disabled is the "Telecommunications for the Disabled Act of 1982," S. 2355. The FCC initiated a related general inquiry into the matter of telephone services for the deaf and hearing-impaired and participated in testimony in the above-cited bill on May 6, 1982. This bill, closely monitored by the Commission, would require the FCC to establish regulations to assure the hearing-impaired reasonable access to telephone service without discouraging or impairing the development of new technology. These regulations should also encourage the use of currently available technology to achieve this result. Under the bill, the FCC, after considering costs and benefits to all users, would have to adopt: (1) Regulations requiring that the design, manufacture, and operation of all coin-operated public telephones be capable of coupling (by internal means) with hearing aids, and (2) regulations setting labeling requirements for each telephone's packaging adequate to inform consumers whether that telephone is compatible with hearing aids. The bill would also authorize the Commission to establish technical standards insuring the compatability of all telephones with hearing aids and to require that other telephones frequently used by the public or provided for emergency use also be compatible with hearing aids.

Other than the efforts described above, the Commission has not expended funds during fiscal year 1982 on specific programs for the elderly. We do, however, anticipate that many of our initiatives permitting new technology introductions such as direct broadcast satellites and low power television, will provide greater uses of telecommunications services which will be of benefit to the elderly community.

I hope this information will be of assistance to your committee, and I appreciate the opportunity to respond.

Sincerely,

MARK S. FOWLER, *Chairman.*

ITEM 18. FEDERAL TRADE COMMISSION

JANUARY 11, 1983.

DEAR MR. CHAIRMAN: In response to your letter of November 9, 1982, I am pleased to forward the enclosed staff summary of Federal Trade activities affecting the elderly for the year 1982.

I hope this information will be of use to the committee. Please let me know if we can provide any further assistance.

By direction of the Commission.

JAMES C. MILLER III, *Chairman.*

Enclosure.

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING THE ELDERLY

VISION CARE

Over 90 percent of persons over the age of 65 wear corrective lenses. The FTC has two programs designed to lower the price of vision care. The first, the "eyeglasses rule," gives consumers the right to obtain a copy of their prescription after having their eyes examined, thereby enabling them to comparison shop for eyeglasses.

The second vision care program, known as "eyeglasses II," is examining several proposals aimed at increasing competition and lowering prices in the vision care market. One portion of the investigation is focused on restrictions which inhibit so-called "commercial" practice of optometry, including restrictions which prevent optometrists from practicing under a trade name, working for a lay corporation, locating their practice in a commercial location, and operating branch offices. In addition, the FTC is examining staff proposals to expand the prescription release requirement contained in the eyeglasses I rule. These proposals would give consumers the right to: (1) Retain a copy of their eyeglasses prescription after it is filled; and (2) obtain a copy of their complete contact lens prescription at the conclusion of the fitting and dispensing process. If adopted they would enable consumers to comparison shop for duplicate or replacement pairs of eyeglasses or contact lenses.

DENTAL CARE

Slightly over half of all persons over age 65 have lost their teeth, and approximately half of this group needs denture care, either because they have no dentures at all or because the dentures they do have are so ill-fitting as to be beyond repair. The high cost of denture care and the maldistribution of dentists in certain parts of the country (most notably in rural and inner-city areas) may prevent many elderly consumers from obtaining denture care. Preliminary evidence from Canada suggests that consumer costs may decrease and access to denture care may increase where dental laboratory technicians, known as "denturists," are permitted to provide dentures directly to consumers. In the United States, virtually all States prohibit non-dentists from selling dentures directly to patients and require that dentures be fitted only by dentists. The FTC is gathering evidence to determine the potential effects on consumers of permitting denturists to offer their services directly to the public.

PRESCRIPTION DRUGS

Persons over the age of 65 comprise 11 percent of the population, but pay 25 percent of the national prescription drug bill. Consequently, savings on prescription drug purchases are especially significant for elderly consumers. In 1979, the FTC staff completed an examination of State laws which prevent pharmacists from substituting lower cost generic drugs for brand name pharmaceuticals, and concluded that modification of these State laws could result in significant consumer benefits, with no compromise in the quality which consumers receive. The Commission's staff, in conjunction with the Food and Drug Administration proposed a model drug product selection statute for consideration by the States, and the staff continues to provide assistance to States contemplating legislation on this issue.

Several States have adopted the model law, in whole or part. The Commission's Bureau of Economics has been working on an investigation to determine if consumers in States that have adopted the model law have enjoyed the benefits the law was designed to provide.

HEARING AIDS

The majority of hearing aids are purchased by the elderly. Statistics indicate that over 40 percent of persons over 65 have some type of hearing impairment. In 1975, the Commission began a rulemaking proceeding dealing with the advertising and sale of hearing aids. Under consideration is a proposal to provide consumers with a 30-day trial option during which a consumer could evaluate the aid and return it, upon the payment of a cancellation fee, if it proved unsatisfactory. The principal purposes of requiring such a trial period would be to discourage manufacturers and sellers from overstating the value of hearing aids, to discourage high pressure sales tactics, and to protect consumers from any risk inherent in the purchase of a hearing aid that the aid will not provide a benefit. The Commission is expected to consider this proposal in mid-1983.

COMPETITION IN THE HEALTH CARE SECTOR

The following projects are aimed at preventing anticompetitive conduct in the health care industry. Their purpose is to stimulate and strengthen competitive forces in the industry, thereby decreasing the need for Government regulation, increasing consumer choice among providers of health care services, improving quality, and lowering the cost of health care. Consumers aged 65 and older spend almost three times as much on health care per capita as do consumers aged 19 to 64. Since many persons over 65 have fixed incomes, these Commission initiatives may have a significant impact on elderly consumers.

American Medical Association (AMA).—In October 1979, the Commission issued a decision in its case against the AMA. The Commission found that the AMA had imposed illegal restrictions on truthful advertising by physicians and medical organizations and on the ability of physicians to work on a salaried basis for hospitals and health maintenance organizations. The Commission ordered the AMA to stop imposing such restrictions. Pursuant to the decision, physicians will be able to provide consumers with truthful information about the services they offer, including information of critical importance to older Americans—e.g., prices for routine services, office hours, whether they accept medicare reimbursement, whether they offer discounts for the elderly, whether they make house calls, and whether they are accessible by public transportation. Hospitals and HMO's will be able to seek to hold down costs by employing physicians on a salaried basis. The Commission's order expressly provides that the AMA may adopt reasonable ethical guidelines to prevent false and deceptive advertising. The Commission's order was upheld, with minor modification, by the U.S. Court of Appeals for the Second Circuit in October 1980. In March 1982, the U.S. Supreme Court affrimed the court of appeals decision, and June 1982, the Commission issued its final order on the matter.

American Dental Association (ADA).—In September 1979, the Commission issued a decision and order accepting the terms of a consent agreement by which, in essence, ADA agreed to be bound in its conduct by the terms of the AMA decision described above, as finally determined by the courts of appeal. This order permits dentists to advertise such services as fitting dentures, and can bring older patients the benefits of price competition. The Commission issued its final order in ADA in August 1982, after the Supreme Court's decision in the AMA case.

Broward County Medical Association.—On June 28, 1982, the Commission issued a final order accepting a consent agreement with the Broward County (Florida Medical Association, whereby the association is prohibited from imposing restrictions on its members' dissemination of truthful information about physicians' prices and services, such as whether they accept medicare reimbursement as payment in full, or provide discounts for senior citizens.

Michigan State Medical Society.[1]—July 27, 1979, the Commission issued a complaint alleging that the society's members conspired to fix prices and to boycott cost-containment procedures instituted by the Michigan Blue Shield Plan. The trial of this case has been completed and an initial decision was issued by the administrative law judge in June 1981, upholding the complaint's allegations and prohibiting future similar conduct. The decision is currently on appeal to the Commission.

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[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

Indiana Federation of Dentists.[1]—On October 18, 1978, the Commission issued a complaint alleging that the Indiana Federation of Dentists obstructed cost-containment measures instituted by insurers. Currently on appeal to the Commission is an initial decision issued by the administrative law judge ordering the dentists to end their collective refusal to supply X-rays used by the insurance companies in making reimbursement decisions.

Texas Dental Association.—On November 19, 1982, the Commission issued a final order accepting a consent agreement with the Texas Dental Association, whereby the association is prohibited from coercing third-party payers to alter provisions of dental care coverage plans, and for influencing its members' decisions concerning cooperation with insurers' efforts to control dental care costs.

American Medical International.[1]—On July 31, 1981, the Commission issued a complaint alleging that AMI's acquisition of French Hospital in San Luis Obispo County, Calif., which gave AMI control of 68 percent of the hospital beds in the county, was likely to substantially lessen competition in that area, and constituted an attempt to monopolize the delivery of acute-care hospital services in the county. The case is currently in trial.

Hospital Corp. of America.[1]—On July 30, 1982, the Commission issued a complaint challenging acquisitions by the Hospital Corp. of America of Hospital Affiliates International and Health Care Corp. as they relate to the hospital service market in Chattanooga, Tenn.

Association of Independent Dentists.—On October 22, 1982, the Commission issued a final order accepting a consent agreement with the Pueblo, Colo. Association of Independent Dentists, whereby the association is prohibited from restricting or advising member dentists against the truthful advertising of their services. The order also bars the association and its members from coercing any third-party payer into altering the terms and conditions of any dental health care plan, such as the reimbursement levels or cost containment programs of these plans.

Physician control of medical prepayment plans.—The Commission has been continuing its nationwide investigation into the extent and effects of agreements by groups of physicians to form, control, operate, or otherwise seek to influence medical prepayment plans (such as Blue Shield plans and HMO's). Such plans make decisions that can significantly affect competition among providers of health care services. For example, they decide how much to pay physicians, what cost-containment measures to use to control the price and utilization of health care services, and whether or on what terms to reimburse providers of health care who are not physicians. When a physician group controls a plan, such decisions might be made with the intent or effect of lessening competition faced by the physicians, and thus could result in higher prices, the unreasonable exclusion of competing providers of health care (which limits consumer choice and harms the competitors), or other anticompetitive effects. Many plans also are medicare part B carriers.

In April 1981, the Commission decided to proceed on a case-by-case basis in addressing the antitrust implications of physician control of medical prepayment plans rather than to propose an industrywide rule, as had been considered earlier. On September 25, 1981, the Commission adopted an enforcement policy with respect to physician agreements to control medical prepayment plans (46 Fed. Reg. 48982 (1981)). The statement explains the analysis and priorities the Commission intends to use in its law enforcement program relating to physician-controlled plans.

MOBILE HOME SALES AND SERVICE

Mobile homes comprise a substantial portion of the low- and moderate-income housing stock, and a large proportion of mobile homeowners are elderly persons. In August 1980, the FTC issued a staff report recommending adoption of a proposed trade regulation rule designed to improve warranty service on mobile homes. Although nearly all new mobile homes were sold with a written warranty, evidence gathered in this rulemaking proceeding indicated to staff that service under these manufacturers' warranties was inadequate, delayed, or simply refused for many owners of new mobile homes who requested such service. In its report, the staff recommended a rule that, among other things, would set 30-day time limits within which mobile home manufacturers or their service agents must complete warranty repairs. The staff's recommended rule is now undergoing evaluation based upon public comments received on the staff report. The staff expects to present its final recommendations to the Commission in early 1983.

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[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

CREDIT

The FTC enforces the Equal Credit Opportunity Act, which prohibits discrimination on the basis of a number of factors, including age. While Federal law permits a creditor to consider information related to age, credit cannot be denied, reduced or withdrawn solely because an otherwise qualified applicant is over a certain age. Furthermore, retirement income must be included in rating a credit application and credit may not be denied or withdrawn because credit-related insurance is not available to persons of a certain age.

The Commission's staff is presently pursuing several nonpublic investigations of creditors for possible illegal discrimination against elderly consumers. These cases involve such issues as discouraging elderly people from submitting applications, refusing to consider income from retirement sources, holding elderly applicants to higher standards than equally qualified younger applicants, and imposing harsher repayment terms on elderly borrowers that are not justified by legitimate creditworthiness considerations.

MEDICARE SUPPLEMENT INSURANCE

More than 50 percent of the Nation's elderly have at least one private health insurance policy to supplement their medicare coverage. Consumers have complained that a variety of problems connected with the sale of medicare supplement insurance exist, including: Confusing policy provisions that inhibit effective comparison shopping; exploitative sales practices that focus on the special vulnerability of the elderly; the sale of policies that duplicate existing coverage; and low rates of return (expressed as the ratio of benefits paid to premiums collected). In 1979, the FTC initiated a study to determine what types of regulatory schemes are most effective in combating these problems. FTC staff has assisted the Department of Health and Human Services in a study of State medicare supplement regulations which will be completed during calendar year 1983.

FUNERALS

The Commission began its funeral industry rulemaking proceeding in 1975. Based on a record developed in the intervening years, the Commission found that certain common business practices used by funeral directors restricted the consumer's ability to choose the funeral goods and services they want, and hindered healthy price competition. As a result, in July 1982, the Commission approved the funeral rule.

The funeral rule is intended to increase consumer access to accurate information prior to and at the time of purchase. The rule would: Require funeral directors to provide consumers with itemized, presale price disclosures; prohibit misrepresentations of legal and cemetery requirements and of the preservative or protective value of embalming, caskets and vaults; prohibit funeral directors from requiring a casket for cremation, or any other tie-in arrangements; prohibit funeral directors from charging for goods and services not specifically ordered, such as embalming; and require funeral directors to give, on request, price information over the telephone.

On September 24, 1982, the Commission issued a notice of its final trade regulation rule in the Federal Register. The notice contained the rule's statement of basis and purpose, the text of the rule, and a regulatory analysis of the final rule. On September 30, 1982, the rule was submitted to the Congress for review in accordance with section 21 of the Federal Trade Commission Improvements Act of 1980. Congress has 90 calendar days of continuous session to decide whether to exercise its right to veto the rule. Given the current legislative calendar, however, it is expected that the rule will be resubmitted for legislative review in the next congressional session. If the Congress does not veto the rule, the rule will go into effect 3 months following the completion of the legislative review process.

DELIVERY OF LEGAL SERVICES

The Commission's staff is preparing a report about the effects of restrictions on the development of legal clinics and closed-panel third-party payment plans for legal services. Legal clinics and closed-panel plans reputedly offer reduced fees and increased access to legal services. These advantages may be of particular benefit to the elderly, whose incomes may exceed limits established by Government-sponsored legal assistance programs, yet may be insufficient to cover the high costs of private bar assistance.

Separate Statement by Commissioner Michael Pertschuk on Commission Programs Affecting the Elderly

December 29, 1982.

No constituency is more central to the Federal Trade Commission's responsibilities than older Americans. From credit discrimination to funeral sales abuses, from porous mobile home warranties to questionable hearing aid sales practices, older Americans are frequent victims of discrimination, deception, and exploitation.

Yet a close look at this year's report shows that the image of a Commission conscientiously defending the interests of the elderly is mostly illusory. Old accomplishments, and old projects fading away, make up most of the list. Precious few new accomplishments are listed. And many long-promised projects are either crawling slowly toward completion or heading for eventual shutdown.

What few changes there are from last year are instructive. The hearing aid rule, slated in last year's report for Commission action by early 1982, is now due for consideration in mid-1983. The venerable mobile home rule is still awaiting final staff recommendations. The fate of both these rules is highly doubtful under Chairman Miller's and Bureau Director Tim Muris' quixotic evidentiary standards for FTC rulemaking. The nursing home investigation has withered. The funeral rule, strongly supported by the American Association of Retired Persons and other older citizens groups, was indeed finally adopted by the Commission this year, but only over the objections of the Chairman and his chief consumer protection and economic advisers.

In my view, this report is evidence of a broad retreat from this agency's responsibility to the older citizens of our country.

ITEM 19. LEGAL SERVICES CORPORATION

December 10, 1982.

Dear Mr. Chairman: The Legal Services Corporation is pleased to respond to your request for the 1982 annual report concerning programs and services for the elderly.

General Access to Legal Services

The Legal Services Corporation (LSC) was established by Congress in 1974 to provide funding for civil legal assistance to low-income persons. The direct delivery of legal services is provided by grantees of the Legal Services Corporation throughout the country. In 1982, there were 326 legal services programs, including 292 basic field programs, 3 migrant programs, 5 State support programs, and 17 national support centers. Since persons 60 years of age and older constitute a sizable proportion of the client eligible population, i.e., persons with incomes below 125 percent of the OMB poverty line, our programs are heavily involved in serving older persons. Individual programs must establish service priorities taking into account the needs of client groups such as the elderly which have difficulties in access to legal services. In 1982, persons 60 years and older made up 14 percent of the total caseload of all Legal Services Corporation programs.

The total number of older persons served in 1982 declined from the total number of clients over 60 served in 1981. The decline can be attributed to a 25-percent reduction in funds appropriated for fiscal year 1982. With the anticipated and actual reductions in funding, local programs experienced reductions in force, reassignment of staff, and closings of branch offices. The number of local offices declined from 1,475 in 1981 to 1,187 in 1982. The changes necessitated by this retrenchment naturally affected the quantity of service to all client groups including older persons. Nevertheless, during the past year the percentage of older clients in relationship to the total client population increased from 12.9 to 14 percent.

Special LSC Programs for the Elderly

In addition to funding legal services programs responsive to the needs of low-income persons of all ages, the Legal Services Corporation funds several programs which specifically concentrate on the elderly. These include the National Senior Citizens Law Center (in Los Angeles and Washington, D.C.), Legal Counsel for the Elderly (in Washington, D.C.), and Legal Services for the Elderly (in New York). The National Senior Citizens Law Center is a national support center which provides assistance to local legal services program staff throughout the country on legal issues unique to the elderly. In 1982, the National Senior Citizens Law Center produced manuals on nursing home law, estate planning for low-income elderly, and legal problems of the rural elderly. Legal Counsel for the Elderly provides legal representation to older persons in the District of Columbia using a combination of staff attorneys and a large contingent of volunteer attorneys and nonattorneys. In 1982, Legal Counsel for the Elderly has developed an innovative approach to legal assistance in the protective services area using volunteer attorneys as guardians and using lay volunteers as representative payees for social security and supplemental security income beneficiaries. Legal Services for the Elderly in New York provides specialized litigation and State support for the elderly, particularly in the areas of employment and pension law.

SPECIALIZED PROGRAMS FOR THE ELDERLY UNDER THE OLDER AMERICANS ACT

A substantial number of local legal services programs have established specialized units or programs to serve older persons. In most instances these specialized delivery units have been financed in large part with funds under the Older Americans Act and to a much smaller extent with social services block grant and local governmental funds. In 1982, 154 field programs (approximately one-half of all such programs) reported a total of $9,137,953 in Older Americans Act funds. Area agencies on aging are required by the Older Americans Act to allocate some title III social services funds to legal services and to contract with an appropriate provided of legal services. Legal Services Corporation programs are identified by statute as suitable providers and have become the principal delivery mechanism for legal services under the Older Americans Act. Where a non-Legal Services Corporation legal provided is selected, that provider is required to coordinate services with the LSC-funded program or programs in the area. The Legal Services Corporation encourages its grantees to become Older Americans Act legal services providers and supports coordination between its programs and Older Americans Act legal services providers where a non-LSC provider is selected.

In addition to serving as a sponsor for Older Americans Act legal services, a growing number of LSC local programs either sponsor or work very closely with a local long-term care ombudsman program. In 1982, 20 such ombudsman programs were physically located in LSC legal services offices.

LEGAL SERVICES SUPPORT AND DEMONSTRATION PROJECTS UNDER THE OLDER AMERICANS ACT

Another aspect of the Older Americans Act legal services program in which our grantees have had substantial involvement has been the title IV legal services support and demonstration program. The Administration on Aging has allocated the bulk of title IV funds earmarked for legal services to grants to State agencies on aging for "legal services developers." These State legal services development grants have served to support and coordinate publicly and privately provided legal activities for older persons in that State. These legal services developers have been particularly helpful to State and area agencies on aging as well as to local legal services programs. In 1982, Legal Services Developers in 6 States were located in LSC programs. In a number of other States, the Legal Services Corporation programs responsible for statewide coordination have increased their efforts to consult with State agencies on aging and legal services developers. Examples of State level planning for training involving State legal services support programs and State agencies on aging include New York and Pennsylvania.

In the area of title IV national legal services demonstrations, Legal Services Corporation programs have also played an important role, albeit diminished from activities in previous years. The National Senior Citizens Law Center and Legal Counsel for the Elderly were the only programs to participate in national demonstration efforts in 1982. However, in 1982, the National Economic and Development Law Center as well as the National Housing Law Center (both LSC national support programs) published articles in the "Clearinghouse Review" financed with title IV funds from the previous year. These articles were on the subjects of community-based long-term care as a local economic development project and on advocacy for the preservation of single room occupancy housing for the elderly.

COOPERATION BETWEEN LEGAL SERVICES AND THE AGING NETWORK

The increasing accessibility of legal services for older persons has been made possible in many instances through a combination of funding under the Legal Services Corporation and Older Americans Act. At the same time, there has been increasing cooperation and consultation between the legal services and the aging services system. In order to support the continuation of such collaborative efforts, the Legal Services Corporation has maintained an Aging Unit within its Office of Field Services staffed by personnel experienced in the delivery of legal services to the elderly. This staff, which in prior years had been detailed to the Administration on Aging, continues to serve as a liaison to the Administration on Aging and to the aging network. The Aging Unit also encourages Legal Services Corporation programs to enhance their efforts on behalf of older clients through working effectively with the aging network. In 1982, the Legal Services Corporation Office of Field Services sponsored the first national conference for legal services programs—"Working Successfully With the Aging Network." Over 130 persons from throughout the country attended this unique training event. Participants consisted of LSC project directors an staff, State legal services developers, Older Americans Act legal services providers (both LSC and non-LSC) and LSC State and national support program staff.

Conference participants heard from leaders in the field of aging including Clinton Hess, Regional Director of the Administration on Aging (region VIII), Sylvia Hougland, secretary of the Kansas Department on Aging, Maggie Kuhn, national conveyor of the Gray Panthers, and George Telisman, president of the National Association of Area Agencies on Aging.

The conference resulted in a shared perception that renewed efforts were in order across a broad range of development in relationships between local legal services and aging services systems. For programs which have mastered the essentials of maintaining a core legal services and aging programs, there is the potential for innovative projects expanding into relatively undeveloped legal areas such as medicare representation, employment rights of older persons, and long-term care. For other programs still struggling to establish a legal services-aging network connection, the conferees recommend developing alliances with bar associations, aging service providers, civic and community organizations, statewide elderly legal coalitions, and State legal services developers. A number of monographs, reports, and articles were produced in the process of assembling materials for the national conference.

Parallel with its efforts to give to its legal services grantees an increased awareness of the aging network, the Legal Services Corporation has endeavored to increase understanding in the aging network for the role legal services can play in assisting needy older persons. In the past year, the Legal Services Corporation has participated as an exhibitor in the 1981 White House Conference on Aging and in the 1982 annual conference of the National Council on Aging. By scheduling the legal services-aging network conference to coincide with the annual conference of the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (N/4A), participants in both conferences were able to meet and exchange perspectives. The Legal Services Corporation also sponsored a workshop at the NASUA and N/4A conference on accountability and quality for legal services providers.

PRIVATE BAR INITIATIVE

The increased involvement of the private bar in the overall delivery of legal services has been a major initiative of the Legal Services Corporation in 1982. This development augurs well for increased access by older persons to legal assistance for a wide range of legal problems. As of September 1982, all Legal Services Corporation field programs have begun to allocate a substantial portion of their LSC funds, i.e., at least 10 percent, to activities which involve the private bar in the delivery of legal services. These activities include both compensated (judicare) and volunteer (pro bono) delivery systems. Such activities of direct benefit to low-income persons generally will naturally assist low-income elderly which make up a significant portion of the population eligible for LSC-funded representation. In addition, a number of programs have targeted a portion of their private bar involvement efforts specifically to services for the elderly. For example, the Arkansas programs are working with the young lawyers section of the Arkansas Bar Association to develop a statewide pro bono program for the elderly. In Philadelphia, private bar involvement funds are going to support the judicare for the elderly program. In Boston, the volunteer lawyers project, a Legal Services Corporation field program, also contracts with an area agency on aging to provide specialized legal services to the elderly. In light of the parallel objectives in both the Legal Services Corporation and Older Americans Act legal services programs to increase private bar involvement, there are good prospects for further collaboration between legal services and the aging network in this critical arena.

A number of substantive areas of legal practice for the elderly lend themselves to shared responsibilities between the resources of the Legal Services Corporation, the Older Americans Act, and the private sector. These include wills, estate planning, and property management. Another developing area is that of employment rights, spurred on by the increased utilization of the Age Discrimination in Employment Act and the high interest of many older persons in full- or part-time employment. A third area, previously mentioned, is the area of competency, guardianships, and protective services. The overwhelming demand for assistance in social security and SSI determinations will also require a combination of public and private legal services. This is a traditional area of expertise for poverty law programs, and there will be increasing demand for training of private practitioners by legal services program staff in the area of public benefits.

LAY ADVOCACY

Along with efforts to increase access to legal services through private bar involvement, a number of programs are renewing efforts to utilize lay advocates. Legal Counsel for the Elderly has long been involved in this activity and in 1982, this LSC program hosted a conference on identifying best practice models for such lay advocates—volunteer utilization. The conference explored the potential for members of organizations such as the American Association of Retired Persons and the Junior League to participate in legal services activities.

CONCLUSION

In sum, despite significant reductions in funding for 1982, the Legal Services Corporation has intensified its efforts to improve the delivery of legal services to the elderly as a vital aspect of its overall responsibilities to serve the legal needs of low-income persons. I trust this information will be of use to the Special Committee on Aging and to the readers of "Developments in Aging: 1982." If I can be of further assistance please do not hesitate to contact me.

Sincerely,

CLINTON LYONS, *Acting President.*

ITEM 20. NATIONAL ENDOWMENT FOR THE ARTS

DECEMBER 27, 1982.

DEAR MR. CHAIRMAN: I am pleased to report to you on the fiscal year 1982 activities of the National Endowment for the Arts concerning arts programing that involves older Americans.

The Endowment encourages and supports the rights of older people to enjoy art. Through advocacy and funding, the Endowment seeks to insure that excellent works of older artists are supported, and that older Americans have opportunities to enjoy the best of our Nation's art.

The Endowment works on all fronts to improve access to cultural programs for older persons, and to eliminate attitudinal, financial, logistical, and architectural barriers. New advocacy and funding activities during this reporting period include the first Symposium on Environmental Design for Aging convened by the American Institute of Architects for design professionals, representatives of the aging field and Federal agency staff; and the only organized exhibition of living American artists' work at the 1982 World's Fair in Knoxville, Tenn., which included paintings by some of this country's best older artists.

In addition, the Endowment's design arts, folk arts, literature, and jazz programs have developed senior fellowship awards which recognize and assist artists who have made significant contributions to their respective fields. During fiscal year 1982, a total of $242,000 was awarded to 27 outstanding individuals. Although age is not a criteria for the fellowships, 20 of the recipients are 60 years and older.

Enclosed is a summary of fiscal year 1982 Endowment-supported projects and advocacy work that involves older Americans. The Endowment and our National Council on the Arts will certainly continue to reinforce our commitment to make the arts available to our older populations as stated in the attached summary.

I trust this information will be useful to you in completing your annual report to the Senate. Please advise me if I may be of further assistance.

Sincerely,

F. S. M. HODSOLL, *Chairman.*

Enclosure.

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS, FISCAL YEAR 1982

The purpose of the Endowment, as declared in the National Council's statement on goals and basic policy, is for foster "professional excellence of the arts in America * * * and equally to help create a climate in which they may flourish so that they may be experienced and enjoyed by the widest possible public."

In fostering professional excellence, we recognize the contributions of many older artists, whose work has enriched our culture, and has served as a model for other artists. In our efforts to make the arts more accessible, we realize the value of including older persons as audiences, volunteers, teachers, staff, creators, and students.

The Endowment endeavors to support only works of the highest quality, and we encourage all grantees to make their programs accessible to the broadest spectrum of the American population in the firm belief that the arts enrich the lives of all individuals, regardless of age.

We are experiencing a new awareness of and new directions for arts programs that involve older people. They are currently participating in many programs around the country in which they are working with professional artists in dance, creative writing, theater, music, and the visual arts. The NEA and State and local arts councils are the primary sources of funding for these activities.

We have a two-pronged strategy for supporting the work of older artists, and making art available to older citizens: (1) Advocacy, technical assistance, and funding through our Office for Special Constituencies; and (2) funding through our discipline and partnership programs.

OFFICE FOR SPECIAL CONSTITUENCIES

The Endowment's coordinator of the Office for Special Constituencies continues to serve as an advocate for arts programing for older adults, and for handicapped and institutionalized populations. Advocacy efforts for special constituencies include: (1) Developing model projects with Endowment programs which demonstrate innovative ways to make programs available to special constituencies; (2) initiating cooperative projects with other Federal agencies in an effort to educate administators and professionals serving constituencies; (3) advocating more support for addressing the needs of special constituencies through the Endowment programs, State and local arts agencies, and other NEA grantees; (4) providing technical assistance to arts organizations about compliance with Federal regulations, including those that mandate nondiscrimination for older adults and handicapped people; and (5) providing technical assistance to individuals and organizations seeking information and assistance in developong art programs.

Model Projects

As I indicated to you in last year's summary of activities, model projects were developed with the Endowment's State Programs office in response to recommendations emanating from the 1981 Symposium on the Arts, the Humanities, and Older Americans. The models are designed to facilitate networking among State arts agencies, humanities councils, and aging agencies.

In 10 States, these agencies are planning and working together as never before to share resources and involve older populations in the best arts and humanities programs. The following are updates on four of the projects:

> The *Iowa* Arts Council has taken step-by-step planning procedures to establish a working relationship between the Arts Council, the Iowa Humanities Board, and the State Commission on Aging, to develop cooperative programs, and to share resources. This working partnership is stimulating more effective methods whereby the three major agenices and numerous additional statewide groups and individuals communicate, cooperate and collaborate to bring quality arts and humanities programs to the older citizens of Iowa.
>
> The Iowa Arts Council has for seveal years pioneered in bringing artists, the arts, and older persons together throughout the State. The Endowment, through this model grant, is supporting the concept of sharing community resources in order to deliver cultural services to more older Iowans.
>
> *Minnesota* is making arts and humanities programs more accessible and affordable, and more widely known to the State's older adults. To carry out these tasks, the St. Paul Council on the Arts and Sciences has organized a consortium of individuals including older persons, humanities scholars, artists, and agencies serving the fields of the arts, humanities, and aging.

The consortium, which is holding a series of statewide forums, has initiated a newsletter to promote better communications among the groups. It will convene a major State conference in April 1983.

The communication process in operation in Minnesota has the necessary ingredients to solidify cooperation between disparate groups, expand existing arts/humanities/aging programs, generate new activities, and involve more older persons in life-enrichment opportunities.

The *Oregon* Arts Commission hs chosen video technology as its model vehicle to reach older adults and inform them of the arts available to them in their own communities. A series of videotaped spot announcements will be distributed to all television stations in the State. They were developed for the purpose of encouraging older adults to get involved in life-enhancing artistic activities. Each spot concludes with a local name and agency for viewers to contact for more information. Video spots, targeted to an older audience, have never been produced before on these specific subjects. Callers responding to the ads will be put on an arts activities mailing list to receive arts news and information. The number of respondents will be recorded to test the effectiveness of this approach.

Sponsored by the *Vermont* Arts Council, the University of Vermont's Fleming Museum has developed a cultural volunteer training program for older adults; formed a broad advisory committee to help build Vermont's cultural network of State agencies and private groups in the arts/humanities/aging fields; sponsored two exhibitions showcasing the work of 27 older artists; convened a 2-day symposium on aging and creativity; and compiled a resource list of older Vermont artists available for placement as artists in the schools.

The Vermont model is also making important contributions to our knowledge of how to reach older populations in a predominantly rural State.

The specific objectives of the model projects are to develop, implement, evaluate, and document ways to make the arts more available to special constituencies. In order to disseminate the results of these and other Endowment-sponsored model efforts more effectively, the Office for Special Constituencies is presently planning a National Symposium on Access to Cultural Programs. Primarily for the national arts service organizations, State arts agencies, and local arts councils, it is scheduled to take place this summer.

Interagency Project

Life Enrichment and the First World Assembly on Aging

As a direct result of the Arts Endowment's interagency agreement with the National Endowment for the Humanities (NEH) and the Administration on Aging (AoA), cultural, educational, and leisure opportunities for older adults were addressed at the first World Assembly on Aging in Vienna, Austria, July 1982.

As reported in my 1981 Summary of activities to the Senate Aging Committee, the Arts Endowment initiated and developed an interagency agreement with the NEH and AoA. The centerpiece of this landmark agreement was a Symposium on the Arts, the Humanities, and Older Americans, which took place February 1981. Sponsored by the three Federal agencies and convened by the National Council on Aging, the symposium proceedings formed the basis for life-enrichment recommendations presented at the first World Assembly.

It is significant that the North American delegates strongly urged that cultural, educational, and leisure opportunities for older adults be considered on the assembly's agenda. The subsequent debate and positive reaction in Vienna is historic in its implications for policy planning in the field of aging.

Without the Arts Endowment's original efforts, these subjects would not have surfaced for serious consideration at the international meeting on aging.

Advocacy

Environmental Design and Aging

As part of Special Constituencies' increased emphasis on work with arts service organizations, the coordinator has been working with the American Institute of Architects (AIA) to determine what may be done to improve the environmental quality of facilities for older Americans. She assisted with the development of an exploratory Symposium on Design for Aging, held June 23, 1982, at the AIA. Thirty-nine architects, designers, professionals serving in the aging field, and representatives of Federal agencies attended the 6-hour symposium. Recommendations included a touring exhibition of some of the best models of facilities designed for older persons, and a comprehensive publication for architects on important design considerations involving older adults. As a result, AIA has allocated $15,000 in its budget to conduct research for the proposed publication, and is investigating funding sources for the proposed exhibition.

1982 World's Fair Arts Exhibition

In the field of visual arts, the Endowment supported the only organized exhibition of contemporary American artists' work at the World's Fair in Knoxville, Tenn., which included paintings by some of this country's best older artists and artists with disabilities. Our Special Constituencies' coordinator worked closely with the Staffs of the World's Fair and the Southern Arts Federation to develop this outstanding exhibition.

Most important, it was an integrated exhibition featuring work of all kinds of American artists, where quality was the only criterion.

Technical Assistance

Access to Cultural Programs

The Endowment is working on all fronts to improve access to cultural programs for older persons, and eliminate attitudinal, financial, logistical, and architectural barriers. These efforts include supporting projects that provide ticket subsidies, outreach activities, touring, and model demonstration efforts. Architectural barriers and the lack of program accommodations often impede some older people with disabilities from fully participating in arts activities. For example, an individual in a wheelchair may not be able to enter an inaccessible theater or concert hall.

The Endowment's 504 regulations, which became effective in May 1979, and our technical assistance for Endowment grantees related to the regulations have caused a number of cultural organizations to evaluate their programs in concert with consumer advisory committees and take the necessary steps to increase accessibility. The director of the Department of Justice's Office for Civil Rights Coordination and Review Division, John Wodatch, stated last month that the Endowment has far exceeded most other Federal agencies in its effort to have recipients comply with the 504 regulations. He added that the Office for Special Constituencies' work with the State arts councils is a model for achieving voluntary compliance.

Endowment Programs

It is my policy to encourage wider access to the arts. Older Americans should have the same opportunities as everyone else to experience the joy that only the arts can bring. Without access to Endowment-supported programs, older people would miss the opportunity to participate in the full range of our Nation's rich cultural resources.

To their credit many Endowment programs have exercised leadership in providing access for special constituencies through grant support. Notwithstanding a reduced budget level for the Special Constituencies Office, I have encouraged our discipline-centered programs to maintain this commitment.

The Endowment's design arts, folk arts, literature, and music (jazz) programs, for example, awarded senior level fellowships to recognize and assist outstanding artists who have made significant contributions to their fields. The majority of the recipients are older Americans. During fiscal year 1982 the design arts program awarded a total of $132,000 to nine designers; five are between 50 and 55 years old, and four are over 60 years of age. Our jazz program awarded jazz master awards in the amount of $60,000 to three older Americans, all of whom are over 65 years. The folk arts program presented 15 National Hertiage Fellowships in the amount of $5,000 each, and 10 of the recipients are over 60 years old.

Other examples of projects that involve older persons in fiscal year 1982 include:

Dance Program

Theatre Development Fund, Inc., in New York, provides a dance voucher program and ticket subsidy program for persons on a fixed and/or low-income. Tickets are provided at a reduced rate to provide everyone with the opportunity to attend New York's broad spectrum of dance program.

Design Arts Program

Housing Services Group in Cambridge, Mass., is exploring specific design issues, problems, and solutions related to "congregate housing" for older people.

Board of trustees of Southern Illinois University of Carbondale, will design a collective greenhouse and farmers' market to be run by the independent elderly and integrated into the local communities.

Expansion Arts Program

DeCordova and Dana Museum and Park in Lincoln, Mass., provides a studio art scholarship program for low-income senior citizens and a summer festival tour event. Transportation and docent tours are also provided.

New Stage, Inc., in Jackson, Miss., provides theater experiences to 2,000 low-income elderly citizens of Jackson, Hinds, Rankin, and Madison Counties.

The Bronx Museum of the Arts in New York City, serves as a cultural center to approximately 40,000 visitors daily, most of them blue-collar, minority, and elderly residents. Workshops are given in the fine arts.

Folk Arts Program

Western Kentucky University in Bowling Green, will mount a major exhibit of folk art wood carvings and oil paintings by Unto Jarvi. Mr. Jarvi will conduct a master class for folk studies and art department students. A videotape will be made of the workshop and a 32-page catalog will accompany the exhibit.

Folk Traditions, Inc., in New York, will document gospel music traditions in the United States.

Mexican American Opportunity Foundation in Monterey Park, Calif., supports a mariachi group composed of senior musicians. These 13 Mexican artists have performed for students, seniors, and children nationwide.

North Carolina Department of Cultural Resources in Raleigh, will complete a film documenting a traditional medicine show as performed by the surviving medicine-show performers, all in their seventies and eighties. The film will include interviews with both the performers and townsfolk on the history of the shows and their place in small-town American life.

Triumphant Gospel Singers Association in Jacksonville, Fla., will present a concert on Afro-American acappella gospel-quartet music. It will be a "gospel reunion homecoming" and an opportunity to honor the older singers from Jacksonville.

Heritage Fellowship: Fifteen outstanding folk artists across the Nation received the National Heritage Fellowship. Recipients have attained stature within their particular art form or have influenced its development in some significant way.

Inter-Arts Program

National Council on Aging, Inc., in Washington, D.C., serves as a clearinghouse for program ideas. The Center on Arts and the Aging maintains a library of arts/aging literature; conducts, cosponsors, and designs workshops and conferences; and concentrates its efforts on building both private and public partnership between the arts and aging fields. A special evaluation conference designed for project directors of NEA's State programs' model projects involving older people will be convened.

Literature Program

Selfhelp Austin Street in Forest Hills, N.Y., will establish weekly workshops in creative writing led by writer Susan Mernit, thus giving instruction, guidance, and advice to senior citizens interested in writing.

Media Program

WNET in New York, is producing a documentary on Mariane Anderson that will be included in a series of documentaries of major American artists.

Contemporary Arts Center in New Orleans, will engage Stevenson Palfi to produce a documentary on folk artist, Papa John Creach.

Museum Program

The *Museum of Fine Arts* in Boston, Mass., will produce a guidebook for its collection of prints, drawings, and photographs. Special editions of this publication will serve the needs of older adults, children, and hearing impaired people.

The *Oakland Museum* in California, continues to offer its museums on wheels which serves senior centers, schools, and hospitals.

Music Program

Des Moines Symphony in Iowa, serves the local region by continuing special matinees for older people and making transportation available to them.

Fresno Philharmonic Association in California, continues its fifth year of repeating subscription concerts with particular emphasis on reaching a greater segment of the community, including senior citizen's centers.

Eugene Symphony Association in Oregon, will engage professional musicians in a string quartet and woodwind quintet to perform in senior citizen's centers.

802 Senior Musicians Fund in New York, continues to offer a series of free performances by the Senior Concert Orchestra to older adults and their families. The ensemble is composed of 60 professional instrumentalists, all age 65 or over. Intergenerational programing is a regular feature of the orchestra as it presents emerging American solo artists.

Toledo Symphony Orchestra in Ohio, brings seven small ensembles from the orchestra to perform in nursing homes and mental health centers in the Toledo area.

Opera Musical Theater Program

Opera America in Washington, D.C., provides technical assistance to its member companies by assisting them in making their programs more accessible to special constituencies and in building strong community ties with older and handicapped populations.

ITEM 21. NATIONAL ENDOWMENT FOR THE HUMANITIES

DECEMBER 15, 1982.

DEAR MR. CHAIRMAN: I am pleased to enclose a report which summarizes major activities for or about the aging supported by the National Endowment for the Humanities in 1982.

It is my hope that you and your committee will find this summary of our activities and plans useful. Please let me know if we can be of any further help to your committee.

Sincerely,

JASON Y. HALL,
Congressional Liaison Officer.

Enclosure.

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1982

I. INTRODUCTION

The National Edowment for the Humanities, established by an act of Congress in 1965, exists to carry out two fundamental objectives: (a) To assist scholars and teachers in the humanities, and the institutions which nourish their work, in investigating the key questions in their scholarly disciplines, and to help them communicate the products of their work through more effective teaching and publication; and (b) to foster throughout the Nation an awareness of the importance and value of the humanities for contemporary life in America.

In carrying out its congressionally mandated mission of furthering the understanding of the humanities in the United States, NEH responds to humanities scholars' and institutions' needs and interests primarily as they are expressed in unsolicited applications for specific projects. Therefore, the agency does not usually set aside fixed sums of money for work in any discipline or for particular areas of the country or groups. As a result, there is no single program for senior citizens using funds specifically allocated for that group; nor is there a program within the agency expressly designed to support the study of the aging process or of elderly people. Rather, both of these interests can be pursued through the full range of Endowment programs, depending on the project's goals and formats.

Although the Endowment does not have specific programs for or about the aging, NEH-supported products of all types (such as print materials, museum exhibitions, radio and television programs) are helping to bring the humanities to senior citizens. In addition to using NEH products, older Americans participate in NEH-supported activities, including scholarship, formal and informal education programs, and discussions of public policy and other questions illuminated by the humanities.

Some of the ways in which older persons participate in the Endowment's programs are discussed in section III of this report.

II. NEH ADMINISTRATIVE ACTIVITIES CONCERNING THE ELDERLY

In 1979, in order to insure that older Americans would have access to Endowment funds and programs, the Endowment developed and published in the Federal Register its proposed regulations under the Age Discrimination Act of 1975. As a result of this publication, comments on the proposed regulations were received and considered. During fiscal year 1983, the Endowment's Equal Opportunity Office will be preparing regulations in final form for publication in the Federal Register.

In the fall of 1980, NEH, the National Endowment for the Arts (NEA), the Administration on Aging (AoA), and the White House Conference on Aging developed a memorandum of understanding, outlining long-term, comprehensive programs of cooperation in the area of humanities, arts, and aging.

A cooperative plan containing an outline of upcoming activities concerning the aging resulted from regular meetings of NEH staff with NEA and AoA. The Endowment also sponsored a miniconference on the use of the humanities by the elderly in February 1981, and attended the December 1981 White House Conference on Aging.

III. PARTICIPATION BY OLDER AMERICANS IN NEH PROGRAMS

The Endowment welcomes applications from persons of any age. Through the regular selection process which emphasizes quality of proposed projects and the centrality to them of the humanities, NEH funds projects involving older individuals as project directors, project personnel, or consultants. Blyden Jackson and Germaine Bree, both in their midseventies, are examples of eminent older scholars, in the fields of literature and French, who have served on the Endowment's National Board of Consultants, a register of some of the most experienced and successful directors and evaluators of curriculum improvement projects in humanities education.

The summer seminars for college teachers program last year included a total of 95 directors, of whom eight were between the ages of 60 and 64, three were between 65 and 69, and two were between 70 and 75. For the same period, 36 participants in seminars were over 55 years, and eight were over 60. The oldest director to date has been Prof. Alpheus Mason, at Princeton, who conducted a seminar on the role of the Supreme Court, at age 79.

Older Americans without scholarly training also make essential contributions to many of the Endowment's projects. For instance, projects for the creation of Native American language dictionaries and tribal histories frequently use elderly members of the tribe as consultants or informants. In another example, a project titled "New York Chinatown History Project: 'Old Chinatown and Its Residents,'" made possible by a grant of $178,136 to the Asian American Research Institute, is using resources provided by the elderly to focus on reconstructing the history of old Chinatown and its residents from the 1870's to 1965. The grant will support research, development, and public programing for the project. The result of this effort will be of interest to the elderly. This project illustrates how older Americans serve as both resources and audiences for many Endowment-funded projects in the humanities.

Certain efforts in education programs and all of the activities supported by NEH to increase understanding of the humanities among the general public reach large numbers of older Americans.

Continuing education.—Many institutions of higher education, including community colleges, are offering courses for credit that make use of NEH-supported media productions and accompanying printed materials. Some of these courses are particularly suited to those elderly students whose mobility may be limited by health or transportation problems since the courses do not require attendance on campus. All provide good opportunities for continuing a lifelong education.

The Endowment's concern with continuing education has gone beyond courses tied to NEH-funded media productions. In 1979-81, the Endowment conducted a special initiative on continuing education. This initiative included seven regional workshops, each with participants from about 25 institutions, with discussions focusing on fashioning programing to meet the needs of a variety of audiences, including the elderly. In the wake of these conferences the Endowment has funded many applications in the area of continuing education. The resulting activities and courses are targeted to adult audiences and are often of special interest to the elderly.

The Endowment has recently revised the makeup of its Education Division. There is now an education program for nontraditional learners. While this program embraces a larger audience, it is also expected to serve older Americans. The program is designed to help improve the quality of education or decrease the unit cost of instruction at institutions—colleges, libraries, and museums, for example—that already have programs for nontraditional learners. As with all Endowment programs, projects funded must be intellectually substantial and thoroughly grounded in the scholarship of the humanities.

Media programs.—The quality radio and television productions supported by the Endowment (e.g., "American Short Story," "Odyssey," the "Edith Wharton Series," "Life on the Mississippi," and the upcoming "Castle") are especially appreciated by older people, many of whom cannot or prefer not to leave their homes. Specific information on media programs and any adjunct material produced is provided to all organizations working for special groups, including the elderly.

Humanities radio programming, like the six-part series of 1-hour programs "Voices from the Thirties," serves a wide audience, including the visually handicapped, who might have limited access to the humanities in other media. For many elderly people confronting problems such as impaired vision and reduced mobility, these Endowment-funded programs provide access to information as well as a mechanism for communicating with others.

Elderly persons are often valuable resources in media projects. A grant of $200,000 to the University of Southern California, Los Angeles, is helping support completion of a 90-minute documentary film, "The American Homefront," about the impact of World War II on the domestic scene in the United States. Elderly persons are helping to provide insights into the history of this era.

Museums and historical organizations humanities projects program.—In this program, the Endowment is making an effort to reach the elderly by encouraging museums or historical organizations receiving project funding to waive entrance fees for senior citizens and others on certain days.

Other projects supported by NEH are designed either to increase understanding of the special problems and challenges facing the elderly or to provide learning experiences in the humanities for older citizens. These are described in section IV of this report. In addition, regrants of NEH funds through humanities committees based in the States have supported many locally-initiated-and-conducted projects of these kinds, some of which are described in section V.

IV. SPECIFIC NEH GRANTS SERVING THE ELDERLY

Continuing until the fall of 1983, the Endowment's grant of $500,000 to the National Council on the Aging for its senior center humanities program has the potential of involving 22.5 million older Americans in the humanities through activities held at more than 800 service centers, (including senior citizen centers, nutrition sites, day care programs, and nursing homes). In addition, during 1982 the Endowment made awards for projects designed—in whole or in part—to increase knowledge about aging or to provide special materials or activities for older persons and for projects which involve the elderly as resources. Examples of this type of program for 1982 follow.

A. Examples of Grants About Aging or the Elderly

The University of Wisconsin at Milwaukee received a grant of $9,952 for a conference on "Aging and the Imagination: Perspective from Literature, Psychology, Anthropology," which will emphasize the psychological study of literature and literary theory's approach to literature and aging.

A grant of $160,000 will support production of an interpretive introduction and dramatization of "Staus" (by Mary Ann Rishel) as the pilot program in the "Growing Old in America," a six-episode series adopted from "American Short Stories" concerned with the theme of old age.

Joel T. Rosenthal, professor of history at the State University of New York at Stony Brook, received a grant to study the quantitative presence, roles, and private lives and outlook of elderly men and women in 15th century England.

B. Examples of Grants for Older Americans or Using Older Americans as Resources

A grant of $24,937 to the National Council on the Aging, Inc., will support planning with National History Day, Inc., for a project which involves older Americans and young people in study and discussion of the U.S. Constitution.

A grant of $2,500 to the University of North Carolina will help support a project in which students will use elderly persons as resources for a radio series on 20th-century history; it will include 365 3-minute audio vignettes on "this day in history" to be broadcast by WFAE–FM to the general public.

A grant of $10,000 supported scripting for a 30-minute film about Hans Moenning, woodwind instrument craftsman and designer. Moennig at 79, is a seminal figure in American music.

A grant to Professor Emeritus William H. Fenton, age 74, supported research which will result in a book on the Seneca Nation, the largest group of Iroquois native peoples.

A grant of $103,804 to Birmingham Southern College supported an extension of the "Birmingfind" project, directed by the Birmingham Alliance for the Humanities. The Alliance proposes to continue development and use of exhibits, booklets, and research material on the city, its five ethnic groups, and neighborhoods. The elderly are valuable resources for this project.

A grant of $139,091 is supporting production for 13 one-half hour radio programs on immigrant woman in America. Diaries, journals, letters, autobiographies, interviews, oral histories, and literary works will be used. The insights and accounts of older persons provide essential resources for the project.

V. STATE PROGRAMS AND THE AGING

The State Programs Division of the Endowment makes grants to humanities councils based in the 50 States, Puerto Rico, and the District of Columbia. These councils, in turn, respond to competitive applications from institutions and organizations within the State for humanities projects of broad benefit to the citizens of the State. Each State group may determine the kinds of humanities activities it wishes to support. Some of the projects funded across the country focus on public issues or matters of contemporary concern to society. Therefore, many projects deal with the topics of biomedical ethics, death and dying, the status of the family within the society, and with other issues of particular concern to the elderly as well as to the general population. Below are presented some examples of projects which are specifically directed towards the elderly or focus directly on the problems of the elderly rather than on the galaxy of related issues of health care, family, etc., mentioned above.

Examples of State Humanities Projects Directly Affecting Older Citizens

Based on information submitted by the State-based councils so far, approximately 120 State regrant aging projects were undertaken by 34 councils in 1982. The following examples suggest the variety of activities supported, especially those whose content and concepts might be duplicated in other communities.

Although the variety of these projects can only be suggested here, they generally include one or more of the following features: exploration of the values and assumptions implicit in our behavior toward the elderly at present, exploration of attitudes toward aging in other cultures or in other periods of American history, and programs of personal enrichment in the humanities directed specifically to elderly audiences.

Florida (Florida Endowment for the Humanities): This project was specifically designed for older adults by the Univrsity of North Florida with the support of two local organizations for retirees. Five afternoon panel/workshops examined the relationships between aging, leisure, and the humanities. Each event began with a panel composed of retired humanists. Philosophers presented views on growing old and the relationship between creativity and longevity.

Idaho (the Association for the Humanities in Idaho): The Boise Council on Aging sponsored "In the Old Ways: A Senior Center Humanities Program." The project used materials developed by the National Council on Aging (through NEH) on American customs and traditions. They were supplemented by films, literature, and lectures on local topics related to "In the Old Ways."

Iowa (Iowa Humanities Board): The University of Iowa offered noncredit college-level courses and campus experiences to more than 800 persons over 60 years of age through Iowa Elderhostel 1982. Twenty-two Iowa colleges and universities, including the three regent universities, two community colleges, and seventeen private colleges and universities participated throughout the summer in 1982.

Kentucky (Kentucky Humanities Council): Eastern Kentucky University offered senior citizens the opportunity to study the 19th-century Shaker religious community. The program included discussion of the Shakers' European origin and migration to the United States; Shaker theology, Shaker music; the place of Shaker women, farming, and economic enterprises; and the Shakers' relation to other Kentucky communities.

Massachusetts (Massachusetts Foundation for the Humanities and Public Policy): Boston University developed a project entitled "A Lifetime of Film." Older adults selected, viewed, and discussed films that were financial successes representing each of the last six decades and portraying some aspect of American society (families, government, value systems, law). Humanities scholars prepared a weekly workbook designed to help participants focus their thoughts and share their ideas about the films.

Maryland (The Maryland Committee for the Humanities): The Kent County Historical Society will interview senior citizens for an oral history project exploring changes wrought by the depression, prohibition, the advent of the automobile and electricity, and the building of the Bay Bridge. A slide/tape show will result, depicting the historical significance of these events for Kent County and its people.

North Carolina (North Carolina Humanities Committee): A grant to Southwestern Technical College made possible a project designed to encourage creative thinking/writing among senior citizens as they reflected with humanist scholars upon American attitudes toward nature, wealth, and success, and the family and individual worth.

Ohio (Ohio Humanities Council): This grant supported a 6-week lecture and discussion series held on successive Wednesday noon hours for the senior citizens served by the Tri-City Consortium on Aging. The series focused on social and political issues reflected in the contemporary novel. The scholar leading the discussions also supplied annotated bibliographies for each session.

Pennsylvania (Pennsylvania Humanities Council): A grant to Allentown College of St. Francis sponsored demonstrations, lectures, exhibits, and discussions at senior citizens centers, elementary schools, and Allentown College on the culture and contributions of Lehigh Valley Indians and other ethnic groups. Six American Indians from the area participated as did Slavic and Germanic groups.

Utah (Utah Endowment for the Humanities): The Utah Coalition of Senior Citizens sponsored "An Oral History of the Minority Elderly of the Greater Salt Lake Area: A Record for Posterity." The elderly represents an untapped reservoir of information about how their communities struggled and prospered. The goal of this project was to capture their irreplaceable first-hand information about the development and growth of a unique place—Salt Lake.

Vermont (Vermont Council on the Humanities and Public Issues): The Rutland Senior Center sponsored a project using National Council on Aging materials developed through an NEH grant, "Self Discovery Through the Humanities." A literary scholar led a discussion of readings related to the work ethic in various guises.

ITEM 22. NATIONAL RAILROAD PASSENGER CORPORATION

DECEMBER 3, 1982.

DEAR MR. CHAIRMAN: Thank you for this opportunity to contribute to your forthcoming annual report from the Special Committee on Aging, "Developments in Aging." As you know, Amtrak is not an agency of the Federal Government but rather a private corporation in the business of providing rail passenger service for the traveling public. However, Amtrak shares the national conscience for the concerns of the elderly, and I would be pleased to relate Amtrak's position and activities on behalf of both elderly and handicapped citizens.

Amtrak recognizes that too often senior citizens and the handicapped feel cut off from the more mobile mainstream of society because they are unable to take full advantage of the Nation's transportation network. Physical barriers can make intercity automobile or motor carrier travel difficult, if not impossible, for the handicapped and financial constraints can often deny both groups access to air travel.

Amtrak remains strongly committed to addressing the special needs of the elderly or handicapped traveler and will continue to make every effort to make rail passenger service both physically and financially accessible.

In January 1982, Amtrak revised its discount fare plan and began offering a 25 percent discount to elderly and handicapped passengers traveling round trip. By eliminating the former $40 minimum fare requirement, Amtrak has been able to extend the comfort and convenience of rail passenger service to a far greater portion of the elderly and handicapped population, particularly those traveling shorter distances. While this discount fare is subject to travel restriction on Metroliner trains and during certain peak holiday periods, as are all our discount plans, the Amtrak senior citizen/handicapped discount program has no limit on length of stay and, at 25 percent, is the largest it the travel industry.

Amtrak luxury bilevel Superliner passenger cars, now in service on all Amtrak's western routes, were designed and built with special accommodations for the handicapped passenger. A unique coach seat or barrier-free bedroom is available on the lower level of each car for safe and easy access. On our eastern routes, Amtrak operates Amfleet or new generation Amfleet II equipment, and both designs have aisles wide enough to accommodate most wheelchairs. Each Amfleet food service car has been equipped with a conveniently located special swivel seat with a fold-down armrest and nearby wheelchair storage space. Corporate policy dictates that any future equipment orders or major car refurbishing programs include design specifications to insure that no passenger whose movement is hindered by a physicial disability be barred from access to Amtrak trains.

To assist the senior citizen or handicapped traveler plan his or her trip in advance from beginning to end, Amtrak maintains a special services desk at each of its five major reservations sales officers. By calling our toll-free reservations number, these travelers can contact our special services staff to arrange boarding and detraining assistance at all Amtrak stations. If necessary, special meals and other on-board services can be made available to those passengers who cannot take advantage of our regular services. The five sales offices also maintain teletypewriters for communications with persons who have hearing disabilities. The special services staffs are able to accommodate nearly all of these kinds of requests; however, Amtrak does require advance notice of the needs of a special passenger before he or she arrives at the station in order to provide the maximum benefits of the service.

I hope this information will be helpful to you in preparation of your 1982 report. Your committee performs vital work in targeting the particular problems of the elderly in this country. If I can be of further assistance, please let me know.

Sincerely,

James H. English,
Vice President, Government Affairs.

ITEM 23. OFFICE OF CONSUMER AFFAIRS

January 25, 1983.

Dear Mr. Chairman: In response to your request, I have enclosed the "Report of Activities of the United States Office of Consumer Affairs During 1982 Relating to Older Americans."

My office is pleased to have the opportunity to contribute to the committee's annual report on aging. As President Reagan's Special Assistant with responsibility for liaison with the aging, I am keenly aware of the needs of the elderly. In 1983, my office will expand its activities to provide even greater assistance to elderly consumers.

Sincerely,

Virginia H. Knauer,
Special Assistant to the President and
Director, U.S. Office of Consumer Affairs.

Enclosure.

Report of Activities of the United States Office of Consumer Affairs During 1982 Relating to Older Americans

The Director of the U.S. Office of Consumer Affairs (OCA) is Virginia H. Knauer, who is also Special Assistant to the President in the White House Office of Public Liaison, with responsibilities for consumer affairs, health care, aging, disabled, and safety concerns. Mrs. Knauer serves as the consumer advisor to the President and directs consumer affairs activities at the Federal level. OCA provides the staff and administrative support to carry out these responsibilities. The President has also designated Mrs. Knauer as the Chairperson of the Consumer Affairs Council, established by Executive Order 12160.

OCA encourages and assists in the development and implementation of programs dealing with consumer issues and concerns; advises agencies on the effectiveness of their consumer programs; exchanges views with business and industry officials by encouraging the development of voluntary employment, consumer protection and information programs; serves as the focal point for the coordination and standardization of Federal complaint handling efforts; works to improve and coordinate education at the local, State and Federal levels; and cooperates with State and local government agencies, and voluntary, consumer and community organizations in the delivery of consumer services and information materials.

The major activities focus on voluntary mechanisms, marketplace innovations, consumer education and information, and conferences to exchange information and develop dialogs. OCA activities also focus on helping State and local government units and consumer community groups to deal with issues affecting consumers.

Highlighted below are major activities having the greatest impact on older Americans.

OUTREACH

The OCA Director represented the White House as an official delegate to the World Assembly on Aging in Vienna, Austria.

The OCA Director convened meetings of representatives of aging constituency organizations to underscore the Administration's concern for senior citizens and seek their support and views on aging policies.

The Director addressed and OCA conducted workshops at conferences sponsored by aging organizations. OCA will conduct a workshop at the National Council on the Aging Annual Conference March 14 in Detroit, Mich. The workshop will focus on "Maximizing Information and Referral Services: A Look at Atypical Networks."

Energy Conferences

On February 4 and 5, 1982, OCA sponsored a conference with the Energy and Aging Consortium on "Building Partnerships: Strategies for Older Americans and Their Energy Suppliers." The conference, held in Washington, brought together over 200 elderly citizens, energy suppliers, government officials and representatives from organizations representing the elderly to develop energy programs that meet the needs of the elderly, particularly those who live on fixed incomes.

A second conference which focused on "Energy and the Elderly: Solving Problems Through Partnerships" was held September 22 and 23, 1982, at the Red Lion Inn in Seattle, Wash. Conference participants, including over 200 utility and energy suppliers, and representatives of consumer and senior citizen organizations, recommended alternatives which are now being reviewed and implemented to meet the energy needs of the elderly.

The OCA Director is being advised by the Energy suppliers of their new programs and the improvements they are making in old programs designed to meet the needs of the elderly.

ThanaCAP

OCA recommended and the funeral industry established ThanaCAP, an industrywide mechanism for handling complaints involving the funeral industry. ThanaCAP was established as a mechanism for reducing the number of expensive and time consuming law suits brought by consumers against the funeral industry. OCA assisted the funeral industry in identifying consumer representatives to participate on ThanaCAP panels.

Listing Area Agencies on Aging in Telephone Directories

Working in cooperation with aging constituency organizations and the Administration on Aging, the OCA Director requested and received favorable response from AT&T's Bell System Companies and General Telephone and Electronics Operating Companies to the listing of State and Area Agencies on Aging upfront in the "Community Services" pages of local telephone directories throughout the country. This cooperative effort with government, consumer organizations and the private sector will largely alleviate the difficulty that many senior citizens encounter in identifying resources in times of need.

National Consumers Week

OCA coordinated National Consumers Week which was held April 25 to May 1, 1982. The President and many Governors and mayors issued proclamations and community classes, workshops, contests, exhibits and displays were held throughout the country. Many of the activities addressed issues of interest to the elderly. OCA is coordinating 1983's National Consumers Week which is scheduled for April 24 through 30.

Consumer Dispute Symposium

OCA will sponsor a symposium entitled "Consumer Dispute Resolution: Exploring the Alternatives" on January 17 and 18 at the L'Enfant Plaza Hotel in Washington, D.C. The symposium will examine practical alternatives to expensive and time consuming law suits and highlight over 30 alternative dispute resolution programs focusing on misleading advertising, landlord-tenant disputes, defective appliances, poorly constructed housing and many others. Many of the issues which will be addressed will be of particular interest to our senior citizens. The American Bar Association and the National Association of Consumer Agency Administrators are cosponsors of the symposium.

Mail Fraud

Consumer mail fraud is one of the most significant problems facing the public, particularly our elderly citizens. The House Subcommittee on Postal Personnel and Modernization reviewed legislation (H.R. 7044) aimed at curtailing mail fraud. The OCA Director wrote to the Subcommittee and asked that it complete the review process as quickly as possible. OCA will continue to review and comment in support of legislation which provides a balanced approach to protecting the legitimate interests of both consumers and honest mail order businesses.

INFORMATION AND EDUCATION

Consumer News, OCA's monthly newsletter, carries articles of general interest to consumers. Many of the articles have discussed proposed legislation and regulations that affect elderly consumers. Also included were articles on eyeglasses, medical devices, announcement of the President's proclamation designating May "Older Americans Month," announcement of the National Council of Senior Citizens' legislative conference, a report on the Director's testimony at fraud hearings, and a report on an industry-wide consumer complaint system for the funeral industry. In addition, Consumer News announced the availability of a packet of new materials about funerals, alternatives to funerals, and laws for professionals who work with elderly consumers. This packet was funded by the Administration on Aging and sponsored by the Continental Association of Funeral and Memorial Societies.

OCA has updated the Consumer's Resource Handbook which contains a section on aging and refers to other sections in the handbook of interest to the elderly such as health care, Social Security, and veterans affairs. The State and local directory section lists government offices responsible for coordinating services for the elderly. Over 500,000 copies of the Consumer's Resource Handbook have been distributed.

OCA published and distributed over 3,000 Federal Directories of TDD Numbers for use by the hearing impaired. Many of our senior citizens have hearing impairments.

OCA published the Energy Consumer Guide which was distributed at the 1982 International Energy Exposition held in Knoxville, Tenn. The Guide lists agencies and organizations which provide useful information on everything from household energy-saving tips to energy conservation projects which are sponsored by local community groups. The Guide is being distributed to elderly constituency organizations.

OCA prepared and distributed over 9,000 fact sheets on the dangers of hypothermia and hyperthermia to weather and consumer reporters and organizations representing the elderly.

INTRAGOVERNMENTAL ACTIVITIES

Interagency Committees

OCA was represented on the following Interagency committees which have a special impact on the elderly.

Federal Advisory Committee to the World Assembly on Aging.

Administration of Aging Interdepartmental Task Force on Information and Referral which assesses the Federal information and referral resources that exist and develops plans for improving and coordinating resources.

Executive Order

The OCA Director is designated by the President to be the Chairperson of the Consumer Affairs Council, established by Executive Order 12160. Executive Order 12160—the Consumer's Executive Order—is a directive to Federal agencies to institute consumer programs that are effective and responsive to the needs of consumers. This action is a logical progression from the consumer representation plans of the 17 executive branch departments and agencies developed in 1976.

The order addressed the problems of citizens in achieving adequate participation in government decisionmaking processes. For example, agencies are required to develop information materials to inform consumers about their procedures for participation. Elderly consumers have been identified as a constituent group which should be reached with information. Under the order, agencies must ensure that groups such as the elderly are being reached.

ITEM 24. PENSION BENEFIT GUARANTY CORPORATION

JANUARY 7, 1983.

DEAR MR. CHAIRMAN: As requested in your letter of November 9, 1982, I am submitting to you, as chairman of the Special Committee on Aging, a preliminary report from our agency concerning programs and services for the elderly. The information in this report will be included in our agency's 1982 annual report for its fiscal year ended September 30, 1982, which is now in preparation. We will send you a copy of such annual report immediately upon its availability.

Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) established the Pension Benefit Guaranty Corporation (PBGC) to administer a pension plan termination insurance program covering tax-qualified, defined benefit pension plans. The program provides termination insurance for single-employer plans and plan insolvency insurance for multiemployer plans. Under both of these insurance programs, PBGC's primary purpose is to guarantee payment of basic benefits as mandated by law (ERISA) to eligible participants whose defined benefit pension plan has terminated. As a result, our program has a direct bearing on the lives of millions of elderly Americans.

The single-employer pension benefit program covers approximately 33 million participants in almost 100,000 defined benefit plans. PBGC insures the payment of promised pension plan benefits to them, up to the limits guaranteed by ERISA, if the defined benefit plan covered by the program terminates without sufficient assets to pay such benefits. In such cases, PBGC assumes trusteeship of the plan and makes basic benefit payments from PBGC funds as required by law.

Since the enactment of ERISA in 1974 to the end of fiscal year 1982, PBGC has received about 43,500 notices of plan termination in the single-employer program. About 98 percent of such terminated plans had sufficient assets to pay all guaranteed benefits. PBGC reviews final distribution as a check on whether the distribution has complied with statutory requirements. With respect to insufficient plans, the PBGC is trustee of about 800 pension plans paying approximately 55,000 plan participants over $100 million annually in benefits. Had PBGC not existed, many of these people might not have received any retirement benefits, or less benefits, when their pension plan terminated.

In September 1980, the Congress amended ERISA, establishing a new multiemployer plan insolvency insurance program which ensures the benefits (according to statute) of approximately 8 million workers who are participants in about 2,000 multiemployer pension plans. Under this program, PBGC provides financial assistance to multiemployer plans lacking sufficient funds to pay benefits. As of the end of the 1982 fiscal year, PBGC loaned more than $465,000 to one multiemployer plan.

Since becoming Executive Director of the Federal agency in May 1982, it has become clear to me that the financial base of the Corporation must be strengthened, if it is to continue to have the funds available to pay with certainty benefits to participants covered by our insurance program, including the retired elderly.

Over the past several months there has been a substantial increase in the number of pension plan terminations. PBGC has, as a result, become trustee of an increasing number of pension plans and has become responsible for insuring the pension benefits up to guaranteed levels of thousands of workers who were active and retured participants of pension plans which did not have sufficient assets to pay benefits called for under the plans.

To meet the increasing calls on PBGC assets, the PBGC's board of directors asked Congress in May 1982 to increase the premium employers pay to the single-employer program from $2.60 to $6 per employee annually. Our Corporation, although a Federal agency, receives premiums only from employers in the private sector. We do not use or rely on funding from Federal taxation.

The PBGC's goal from a financial viewpoint is like that of any well-run insurance company. It is to make sure that it is financially sound to the degree that we can with certainty protect the pension benefits of 33 million American workers and elderly retired insured by our program.

In recent months the PBGC has received considerable publicity mostly due to the number and size of company bankruptcies and pension plan terminations, such as Braniff Airways. Other large plan terminations loom on the horizon. In this connection we are endeavoring to help employers, the general public, and plan administrators better understand PBGC's role in insuring pensions payable under private, defined benefit pension plans. Significantly, also, legislative amendments have been proposed by the PBGC and are currently under consideration by the administration. Such amendments would help to encourage the maintenance and continuation of voluntary defined benefit pension plans, and assure the timely and uninterrupted payment of pension benefits to participants and beneficiaries.

Retirement planning has become a priority for most of America's 110 million workers. Continuance of a monthly pension benefit is on the mind of almost every retired worker today. We are doing our best to see to it that the PBGC properly performs its role and responsibilities in the pension field.

Thank you for giving me the opportunity to provide you with this brief report of our program.

Sincerely yours,

EDWIN M. JONES,
Executive Director.

ITEM 25. POSTAL SERVICE

DECEMBER 9, 1982.

DEAR MR. CHAIRMAN: This is in response to your request of November 9, 1982 for information on postal programs affecting the elderly. The Postal Service's most important contribution to older Americans continues to be the maintenance of inexpensive, reliable universal mail delivery. While the mails benefit all citizens, they have traditionally been recognized as an especially important underpinning to the family, social, and business activities of senior citizens who find it difficult to get around. This is particularly true for those who live in rural areas or small towns.

It is their greater reliance on postal services which unfortunately makes the elderly the target of fraudulent mail order activities. These illegal endeavors, which range from work-at-home and franchise schemes to investment, land, and medical frauds, generally focus on older people's need to maintain financial security. Preventive and law enforcement efforts to keep the mails as free as possible of activity of this kind enable all consumers, and particularly older Americans, to rely on the mails with greater confidence.

Several laws are used by the Postal Service to protect the public from the effects of fraudulent schemes. One of these, the criminal Mail Fraud Statute, 18 U.S.C. § 1341, is the oldest and perhaps the most important consumer protection law. It provides penalties of up to 5 years in prison and a $1,000 fine for the use of the mails to further any fraudulent scheme. The Civil False Representation Statute, 39 U.S.C. § 3005, enables the Postal Service, after a hearing, to stop the delivery of mail to an address found to be used for a "scheme or device for obtaining money or property through the means of false representations." Under section 3007 of the same title, the Postal Service can go to court to get a temporary restraining order against delivery to a person suspected of a violation, pending action on the mail stop order. The 97th Congres has under consideration proposed legislation to improve the effectiveness of the present statutory scheme. S. 1407, unanimously passed by the Senate, and H.R. 7044, favorably reported by the House Committee on Post Office and Civil Service, would allow direct purchases of items under investigation, permit civil "investigative demands" to obtain documents relative to advertising claims, and authorize the courts to impose civil penalties for repeat violations of the statute.

The Postal Service also engages in educational efforts aimed at helping people avoid being taken in by deceptive mail order schemes. Under an ongoing consumer protection program specially trained postal inspectors work with the media, consumer protection groups, investigative agencies, and groups such as the American Association of Retired Persons, to alert consumers to the dangers of fraudulent promotions. Particular attention is given to informing the elderly about the kinds of fraudulent schemes which are aimed specifically at them.

Since large amounts of social security and other aid payments are sent through the mails, senior citizens also benefit from the Postal Service's efforts to combat the theft of mail. The large volume of checks, and the ease with which stolen checks can be cashed, has created a climate which is conducive to mail theft. Since these checks represent the only income of many elderly recipients, their theft causes great hardships. The Inspection Service continues to work with Federal and local authorities to prevent checks and other items from being stolen, and to apprehend those suspected of specific mail thefts.

In addition to its activities in the enforcement areas, the Postal Service maintains several programs designed to provide postal services to the elderly and others unable to reach their post offices. Through the stamps-by-mail program customers, may order stamps and stamped envelopes by using postage-paid forms. Each order, which must include a 40-cent handling fee, is filled locally and returned to the customer within 48 hours. The consumer service card program, also available to all customers, provides another opportunity for the elderly who find it difficult to get to the post office to handle problems by mail. These cards, furnished by mail carriers, bring to the attention of Postal Service headquarters and the local post office any complaints or requests the customer wants to register concerning mail delivery or other services.

A unique program aiding the elderly, the handicapped, and those who live alone received the official endorsement of the Postal Service and the National Association of Letter Carriers in 1982. Under this program, entitled "Carrier Alert," letter carriers keep a special watch on the mail delivery boxes of participating customers. If mail is not removed in a reasonable time, the Postal Service notifies a local sponsoring civic group which investigates and provides any necessary assistance.

The programs to facilitate the elderly's access to the postal system, along with our continuing efforts to protect that system from abuse, demonstrate the strong commitment of the Postal Service and its employees to meeting the needs of the Nation's senior citizens. I hope our older citizens will continue to take advantage of these programs, and to seek our assistance if they feel they have been harmed by fraudulent or deceptive schemes involving the mails. We are here to help, and their problems will receive prompt and conscientious attention.

Sincerely,

William F. Bolger,
Postmaster General.

ITEM 26. RAILROAD RETIREMENT BOARD

December 13, 1982.

Dear Mr. Chairman: In response to your letter of November 9, 1982, we are enclosing a report summarizing the U.S. Railroad Retirement Board's program activities for the elderly during fiscal year 1982.

We look forward to your committee's report on "Developments in Aging: 1982."

Sincerely,

Beatrice Ezerski,
For the Board.

Enclosure.

U.S. Railroad Retirement Board

The U.S. Railroad Retirement Board is an independent agency in the executive branch of the Federal Government. The Board's primary function is to administer comprehensive retirement-survivor and unemployment-sickness benefit programs for the Nation's railroad workers and their families, under the Railroad Retirement and Railroad Unemployment Insurance Acts. In connection with the retirement program, the Board has administrative responsibilities under the Social Security Act for certain benefit payments and railroad workers' medicare coverage.

Because of its experience with railroad benefit plans, the Board has been given, in recent years, administrative responsibility for certain employee protection measures provided by other Federal railroad legislation, such as the Regional Rail Reorganization Act, the Northeast Rail Service Act, and the Milwaukee Railroad Restructuring Act.

RAILROAD RETIREMENT LEGISLATION

The Omnibus Budget Reconciliation and Economic Recovery Tax Acts enacted in 1981 included major amendments to the Railroad Retriement Act and Railroad Retirment Tax Act which were generally effective October 1, 1981, the beginning date of the 1982 fiscal year.

Financing

Both railroad employee and employer retirement taxes were rasied by the amendments, primarily to fund the railroad retirement annuity protion called tier II, which is payable over and above the first tier, social security level, annuity portion.

While tier I taxes on employees and employers remained at the same rate as social security taxes, 6.65 percent in 1981, the additional tier II tax paid by employers was increased, beginning October 1, 1981, by 2.25 percent to 11.75 percent. And, employees began paying a tier II tax of two percent.

The amendments gave the Railroad Retirement Board the authority to borrow from U.S. Treasury general funds if Railroad Retirement Account funds are insufficient to pay benefits during a month. The amounts borrowed in any fiscal year cannot exceed income due the acocunt for that year from its financial interchange with the social security trust funds. Any borrowed amounts are to be repaid with interest.

In any fiscal year in which the authority is used to borrow an amount equal to 50 percent or more of estimated financial interchange income, the law requires railway management and labor, and the President, to make further funding proposals to Congress.

While the financing provisions of this legislation were based on reasonable railroad employment assumptions, the extended and deepening recession in the national economy has, since 1981, effected a dramatic drop in rail employment. During the 1982 fiscal year, rail employment dropped from 500,000, at the beginning of the year, to 435,000 at its close. This decrease in railroad employment has adversely affected the financial condition of the railroad retirement system, in the same way the social security system has been affected, by reducing payroll employment tax revenues. Consequently, it appears that the railroad retirement account will be using over 50 percent of the limit of its borrowing authority in the near future, in which case railroad management, labor, and the President will be required by law to make further funding proposals to Congress.

Employee Annuities

Under the two-tier railroad retirement formulas provided by the 1974 Railroad Retirement Act, the tier I portion is computed like a social security benefit, based on both railroad retirement credits and nonrailroad social security credits. Tier II, which is comparable to an industrial pension, is computed under a separate formula, based on railroad service alone. In some cases, an additional payment, reflecting vested dual benefit rights, is also added to the annuities of those who had vested rights to both social security and railroad retirement benefits before 1975. A supplemental annuity is also payable by the Railroad Retirement Board to career employees with long service.

Benefit Formula and Cost-of-Living Increases

For new retirees, the 1981 amendments provided a simplified benefit formula for the tier II portion of their annuities. Tier II benefits are equal to seven-tenths of 1 percent of the employee's average monthly earnings in the 60 months of highest earnings, times years of service, less 25 percent of any employee vested dual benefit amount also payable. Under the new formula, in most cases, the amounts awarded active railroad employees upon retirement will automatically keep pace with average wage increases in years prior to retirement.

The amendments also continued annual July 1 employee tier II cost-of-living increases equal to 32.5 percent of the rise in the Consumer Price Index between the first calendar quarter of the year and the corresponding quarter of the previous year, payable to employees whose annuities begin June 1 or earlier. Under prior law, there was no provision for further cost-of-living increases in the tier II formulas after 1981. Tier I cost-of-living increases, which are for the same percentage as social security cost-of-living increases (100 percent of the increase over the year in the Consumer Price Index), continue automatically.

The new law also modified the cost-of-living and dual benefit computational steps in annuities reduced for early retirement, so that they are consistent with social security computations and the intent of the 1974 act. Also, the rounding of years of service in employee annuity computations was phased out.

Current Connection Requirement

A "current connection with the rail industry" is required for a supplemental annuity, occupational disability annuity or survivor benefit paid by the Railroad Retirement Board. The requirement is normally met if the employee worked regularly in the railroad industry close to the time of retirement or death. Regular nonrail employment in the interim can break an employee's current connection.

The amendments maintain a current connection for purposes of supplemental and survivor annuities, despite interim nonrail employment, if the employee completed 25 years of railroad service, was involuntarily terminated without fault from the railroad industry, and did not thereafter decline a suitable offer to return to work in the railroad industry. This provision was effective October 1, 1981, but only for employees still living on that date and who left the rail industry on or after October

1, 1975, or who were on leave of absence, on furlough, or absent because of injury on October 1, 1975.

The amendments also added the National Transportation Safety Board to four other Government agencies administering railroad laws, for which an employee may work after leaving rail service without breaking a current connection. This provision is retroactive to January 1, 1975.

Supplemental Railroad Retirement Annuities

Under prior law, an employee who worked in railroad service after a specified closing date, based on his or her 65th birthday, would permanently forfeit entitlement to a supplemental annuity payable by the Board. This restriction was eliminated for those whose closing dates did not occur before October 1, 1981. In addition, supplemental annuity eligibility is now limited to employees with railroad service in at least one month prior to October 1981.

Vested Dual Benefit Payments

The Railroad Retirement Act of 1974 coordinated railroad retirement and social security benefit payments to eliminate certain duplications for those receiving benefits under both systems. However, pre-1975 dual benefit rights were, in effect, preserved for individuals meeting certain vesting requirements. Although their railroad retirement annuities are reduced for social security entitlement just as for all annuitants, these annuitants receive a vested dual benefit payment to partially offset the reduction.

The costs of these payments, which were intented to be funded solely out of U.S. general revenues, have been substantially more than the amount estimated at the time the 1974 act was passed, and substantially more than the funds that have been appropriated. Also, in recent litigation, individuals sought to expand eligibility to nondependent male spouses and survivors who were not eligible for dual benefits at the time the 1974 act was enacted.

The 1981 amendments established a dual benefits payments account, separate from the regular railroad retirement account. The Board is required to prorate vested dual benefit payments from the new account amount so that the amounts paid to annuitants in a fiscal year do not exceed the annual amount appropriated. In addition, the amendment limited eligibility for further awards and modified the computation. While vested employees may still qualify for these dual benefit payments on the basis of their own pre-1975 earnings under both systems, the amendments precluded, upon enactment, and award of these payments to an employee based on a spouse's social security coverage and awards to auxiliary beneficiaries. Also, the preretirement cost-of-living increases computed in these payments were frozen as of January 1, 1982.

Fiscal year appropriations.—Since the vested dual benefit appropriation for the 1982 fiscal year was expected to be $350 million, which was only 79 percent of the cost of total projected payments for the year, the Railroad Retirement Board was required to reduce the vested dual benefit portion of affected annuities by 21 percent beginning October 1, 1982. However, the actual appropriation was larger than previously anticipated, allowing for payments with only a 15-percent reduction, retroactively, for the balance of the fiscal year. At the end of the fiscal year, a supplemental appropriations bill was passed, providing full payment for the last 2 months of the year. Based on the anticipated appropriation for the 1983 fiscal year, the Board began paying the vested dual benefit annuity portion without any reduction on October 1, 1982.

Spouse Annuities

The 1981 amendments extended railroad retirement spouse benefits to the divorced wives or husbands of retired employees, if the divorced wife or husband is not remarried, has attained age 62, was married to the employee for at least 10 years, and the employee is age 62 or over. Other eligibility requirements are the same as for spouses. The amount payable is limited to the tier I portion of an annuity, which is equal to what social security would pay, and subject to offset if other railroad retirement or social security benefits are also payable. A divorced wife or husband receiving a spouse benefit is also considered a qualified railroad retirement beneficiary for medicare purposes.

The formula for the spouse tier II annuity portion was changed from 50 percent of the employee's tier II portion to 45 percent. However, the spouse maximum, which previously set a limit on the amount of a spouse annuity, was eliminated. Tier II cost-of-living increases will be continued at the same rate as for employees (32.5 percent of the increase over the year in the Consumer Price Index). To conform with social security law, the spouse age reduction factor was changed from 1/180 to 1/144 for each month the spouse is under age 65 when she or he elects to receive a reduced annuity (from a 20-percent reduction at age 62 to a 25 percent reduction).

The same provisions for prorating vested dual benefit payments applied to employees were applied to spouses receiving these payments. In addition, the award of new spouse vested dual benefit payments was precluded as of the enactment date of the amendments.

Survivor Benefits

The 1981 amendments provided survivor benefits for surviving divorced wives and husbands, divorced mothers and fathers and remarried widows or widowers. Eligibility requirements are the same as under the Social Security Act, and the amounts payable are limited to what social security would pay (tier I only). The survivor must be at least age 60 or have children in her(his) care. If divorced, the survivor must have been married to the employee for at least 10 years, unless she(he) has children in care.

A new survivor tier II formula was provided, based on the new "high 60" employee tier II formula amount. Under the new survivor formula, a widow or widower generally receives 50 percent of the employee's tier II amount, each child receives 15 percent, and surviving parents receive 35 percent. The minimum total tier II amount payable to a family is 35 percent of the emplyee's tier II amount, and the maximum is 80 percent. During a 5-year transition period, most awards will continue to be made under the previous formula.

Survivor tier II amounts are increased annually by the same percentage as employee and spouse tier II amounts—32.5 percent of the increase over the year in the Consumer Price Index. Tier I increases continue at 100 percent of the increase in the Consumer Price Index, the same as social security benefits.

Widows' vested dual benefit payments in force became subject to proration, just as for employees and spouses. Also, the new law precluded the award of any new vested dual benefit payments to survivors as of the enactment date of the amendments.

BENEFITS AND BENEFICIARIES

During fiscal year 1982, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $6.1 billion. Retirement and survivor benefit payments amounted to $5.7 billion, an increase of $439 million over the same period 1 year earlier. Unemployment and sickness benefit payments totaled $346.1 million, an increase of $88.6 million from the preceding fiscal year.

The number of beneficiaries on the retirement-survivor rolls on September 30, 1982, totaled 991,000. The majority (81 percent) were age 65 or older. At the end of the fiscal year, 445,000 retired employees were being paid a regular annuity averaging $628 a month, about $60 higher than a year earlier. In addition, 197,000 of these employees were being paid a supplemental railroad retirement annuity averaging $51 a month. Some 234,000 spouses of retired employees were receiving an average annuity of $280 a month at the end of fiscal 1982. Of the 323,000 survivors on the rolls, nearly 289,00 were aged widow(er)s receiving an average annuity of $428 a month. Some 854,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the medicare program at the end of fiscal 1982. Of these, 837,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to see some 210,000 railroad employees during the fiscal year. However, only about $0.6 million (less than 1 percent) of the benefits went to individuals age 65 or older.

MAJOR RAILROAD RETIREMENT COURT DECISIONS

Denberg v. *The Railroad Retirement Board* is a class action which was filed in the U.S. District Court for the Northern District of Illinois. The plaintiffs seek spouse benefits, under the The Railroad Retirement Act of 1974, for periods prior to March 1977, for those male spouses who were denied spouse annuities because of the dependency provision found in section 2(c)(3)(ii) of the act. The dependency was ruled unconstitutional in the case of *Railroad Retirement Board* v. *Kalina*, 431 U.S. 909 (1977). As a result of that decision, the Board has been paying husbands' and widowers' annuities, regardless of dependency, since March 1, 1977. On June 16, 1981, the court issued a decision in the *Denberg* case, granting the plaintiffs' motion for summary judgment and denying the Board's motion for summary judgment. The court the Board to pay spouse annuities to class members retroactive to March 1974. The Board has appealed the court's order to the U.S. Court of Appeals for the Seventh Circuit. Oral argument was held in May 1982 and the case is now under advisement with the court.

In the case of *Linquist* v. *Patricia Roberts Harris and the Railroad Retirement Board*, brought before the U.S. District Court for the Western District of Missouri, the plaintiff, who receives a widow's annuity under the Railroad Retirement Act and an old-age benefit under the Social Security Act, is challenging the application of the excess earnings provisions to both her railroad retirement annuity and social security benefit. The plaintiff claims that the imposition of excess earnings deductions under both acts amounts to a "double deduction," whereby her total benefit under the two acts is reduced dollar for dollar for her excess earnings. The plaintiffs is (1) seeking class certification of this action, and (2) requesting that the court order declaratory and injunctive relief against future application of this so-called "double deduction," as well as monetary relief for benefits deducted in the past resulting from application of this "double deduction." The Board has filed a motion to dismiss and a motion for summary judgment, contending that the court has no jurisdiction to review Board determinations and that the imposition of the "double deduction" is not unconstitutional.

Burns v. *United States Railroad Board* is a petition for review of a final Board decision in the Court of Appeals for the District of Columbia. It includes the same issues as *Linquist* v. *Harris* discussed above.

Frock v. *United States Railroad Board* involves the constitutionality of a provision of the 1981 amendments which precluded, upon enactment, the award of vested dual benefit payments to an employment based on a spouse's social security coverage. The Court of Appeals for the Seventh Circuit upheld the constitutionality of that provision. The petitioners have asked the U.S. Supreme Court to review the Seventh Circuit's decision.

ADMINISTRATIVE GOALS AND ACCOMPLISHMENTS

In order to more effectively guide its long-range development, the Board has instituted a formal planning process. A new unit was permanently established to coordinate strategic planning for the Board, as well as to administer a system of shorter range operations planning throughout the agency. With the assistance of a consulting firm, a strategic plan was drafted, outlining the agency's major goals and objectives for fiscal years 1982 through 1986. The operations planning system became operational at the beginning of the 1982 fiscal year.

During the year, the Board engaged an outside consultant for assistance in reevaluating its information gathering and electronic processing systems. In addition, the Board is developing a rate history file, which will allow considerable post-adjudicative claims work now done manually by claims examiners to be done faster and more accurately by electronic data processing equipment.

A pilot study was conducted to determine the impact and cost-effectiveness of video display terminals in the Board's field offices. The terminals establish direct contact with the headquarters computers and provide field personnel immediate up-to-date benefit information for answering inquiries from annuitants.

An experimental toll-free telephone system was planned in fiscal 1982 and implemented in Ohio on a temporary test basis in fiscal 1983. The toll-free number enables Ohio residents to call for infoirmation on all types of benefits, and also for matters such as pending claims, delayed payments, rate changes and direct deposit. It supplements assistance facilities still provided by field offices.

The Board has initiated various other programs to improve the efficiency of operations. Greater agency-wide emphasis, guidance and coordination is being provided toward reducing waste, fraud and abuse. The appeals process available to persons dissatisfied with the decisions on their claims under the Railroad Retirement Act has been revised in order to shorten the time it takes to resolve an appeal. Also, the Board's largest organizational bureau was reorganized to streamline management.

ITEM 27. SMALL BUSINESS ADMINISTRATION

DECEMBER 17, 1982.

DEAR MR. CHAIRMAN: In response to your request for information concerning our activities on behalf of older persons, we are pleased to advise that the Office of Civil Rights Compliance of the Small Business Administration is continuing to actively enforce regulation B (12 CFR 202) of the Federal Reserve System and its own requirements under the Equal Credit Opportunity Act, as amended.

During fiscal year 1982, Small Business Administration (SBA) monitored 12,310 recipients for compliance with the prohibition of discrimination on the basis of age under the Equal Credit Opportunity Act and the Age Discrimination Act. The SBA Notice of Proposed Rule Making in 44 FR 60032 on October 17, 1979, which effectuates the provisions of the Age Discrimination Act of 1975 is still pending. Health and Human Services, the lead agency in implementing the provisions of the Age Discrimination Act, is still negotiating with OMB the finalization of similar regulations throughout the Government. Compliance with these proposed regulations ensures older persons equal opportunity in credit and in services by recipients of Federal financial assistance without regard to age.

Since its establishment in 1964, SBA's volunteer program which utilizes the services and expertise of active and retired business executives, Service Corps of Retired Executives (SCORE), has counseled well over 1 million small businesses. Its 11,500 volunteers, organized into 398 chapters and located throughout the United States, counseled well over 273,118 small businesses during fiscal year 1982.

Sincerely,

JAMES SANDERS, *Administrator.*

ITEM 28. VETERANS ADMINISTRATION

JANUARY 10, 1983.

DEAR MR. CHAIRMAN: I am pleased to respond to your request of November 9, 1982, for a report of the Veterans Administration's activities on behalf of older persons.

The VA has developed a high quality system that provides health care for more than 50,000 elderly veterans every day. Meeting the medical needs of older veterans constitutes the current greatest challenge to the VA.

Thank you for allowing us the opportunity to share this information with you.

Sincerely,

HARRY N. WALTERS, *Administrator.*

Enclosure.

I. INTRODUCTION

The contributions of the Veterans Administration to older Americans come from three main sources: Compensation and pensions to veterans or their dependents—over 1.6 million persons in all; burial benefits to all eligible veterans; and medical care to over 50,000 elderly veterans every day. In addition, the veteran of World War II, whose average age is now 62 years of age, was the principal target of the VA's education and housing assistance programs established after World War II.

Meeting the medical needs of older veterans constitutes the current greatest challenge to the VA. Older persons typically account for more than twice as many hospital admissions as younger ones and, once admitted, require twice as many hospital days for recovery. So, even if there were no increase in the total number of veterans seeking medical services from the VA, the demand on our existing hospital facilities is expected to rise steadily as the relative number of older veteran beneficiaries increases. By 1990, approximately two out of three males age 65 years and over will be veterans. In 1981, over 30 percent of all the VA's medical resources—hospital out patient and extended or long-term care—went to veterans 65 years of age or over. By 1990, that fraction will be about 40 percent.

The VA has initiated a grassroots strategic planning process—medical district initiated planning process (MEDIPP)—to improve utilization of its medical resources. A primary concern in that process is the development of overall plans to care for older veterans. In addition, steps have been taken to improve communication between central office program officials concerned with aging and medical center staff. An overall effort to develop an improved long-range plan for the health care of older veterans was initiated by the Chief Medical Director. In all of the efforts just mentioned, the VA is actively seeking better use of existing and planned State and community facilities and programs, as well as an expansion of its own resources required for the care of older veterans.

Extended care bridges full hospital care and independent living with a diversity of medical programs ranging from nursing home care, on the one hand, to hospital based home care and residential care programs on the other. Because the relative number of chronic medical problems increases with age, the importance of these programs for older veterans is steadily increasing in the VA. In fiscal year 1982, almost half of the approximately 50,000 veterans in extended care programs were 65 years of age and over. As is the case with other health care programs in the Nation, the VA is vigorously increasing the number and diversity of extended care programs, particularly those which provide care outside of nursing homes or domiciliaries. However, the demand for additional nursing homes in the VA is relentlessly increasing. Extended care programs improve the utilization of acute care facilities by providing appropriate programs for patients who no longer require hospital care. At the same time, the growth of extended care programs places additional demands for acute hospital care since virtually all of the veterans in long-term care programs look to the VA for their acute care which may supervene.

In the detailed reports that follow, four major themes will be stressed: First, improved coordination of all VA efforts for the medical care of older veterans is occuring both in the VA central office and VA medical centers. Second, efforts are underway to improve the quality of life and care for the older veterans in specific VA medical programs by improved admission and utilization of existing programs and the development of alternatives to them. Third, extended care resources available to veterans are being increased by attempts to reduce costs of construction as well as the judicious use of conversion of existing space. The fourth, which spans all of the others, is the provision of model programs of long-term care, trained personnel in geriatrics and gerontology, geriatrics, and health care delivery.

II. Geriatrics and Extended Care Programs

VA NURSING HOME CARE

The nursing home care units located in VA medical centers provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational, and spiritual activities. Nursing home patients typically require a prolonged period of nursing supervision and rehabilitation to attain and maintain optimal functioning.

In fiscal year 1982, 14,505 veterans were treated in VA nursing homes which had an average daily census of 8,442.

Three new 120-bed nursing home care units were activated at VA medical centers in Gainesville, Fla.; Livermore, Calif.; and Wilkes-Barre, Pa. These and other changes resulted in a net increase of 132 operating beds for a total of 9,105 beds at the end of fiscal 1982 at 97 VA medical centers.

COMMUNITY NURSING HOME CARE

This is a contract program for veterans who require skilled or intermediate nursing care in making the transition from a hospital to the community. Veterans who have been hospitalized in a VA facility for treatment, primarily of a service-connected condition, may be placed at VA expense for as long as they need nursing care. Other veterans may be eligible for placement in community facilities at VA expense for a period not to exceed 6 months. The program requires assessment of participating facilities and followup visits to veterans by teams from the VA medical centers.

Fiscal year 1982 saw a large increase in community nursing home placements. During this year, 31,658 veterans were treated in the program. This represents a 12-percent increase over fiscal year 1981. Similarly, the number of nursing homes under contract increased to 3,100, or 7 percent over fiscal year 1981. The average daily census in these homes for fiscal year 1982 was 9,533. The average age of veterans treated was 67.7 years; 56.2 percent were 65 years or older; and their average attained length of stay was 1.09 years. Approximately 46.9 percent were receiving compensation for service-connected conditions and 27 percent were receiving VA pension.

Since April 1981, the VA has, through arrangements with States (coordinated with the Department of Health and Human Services), attempted to make maximum use of inspections conducted for medicare or medicaid inspection, reducing the amount of time and duplication in the nursing home inspection efforts of the VA. Due to cutbacks in inspection efforts of some States, however, the VA medical centers sometimes find that they must continue to conduct a full-team inspection of nursing homes. While the general VA policy of greater reliance on State inspections continues, this policy can only be carried out where there is a strong State inspection foundation.

VA DOMICILIARY CARE

Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by age, disease, or injury and are in need of care, but do not require hospitalization or the skilled nursing services of a nursing home.

New program directions have created a better quality of life for veterans requiring prolonged domiciliary care and have prepared veterans returning to community living for active participation in various community resources.

Special attention is being given to older veterans in domiciliaries with a focus on keeping them active and productive in the domiciliary as well as encouraging their integration into existing senior centers and other resources in the community.

In fiscal year 1982, 14,535 veterans were treated in VA domiciliaries which had an average daily census of 7,087.

Patients at several domiciliaries are involved in senior center activities in the community as part of a focus on community integration. Other specialized programs in which older veterans are involved include foster grandparents, handyman assistance to senior citizens in the community, and adopt-a-vet.

ADULT (GERIATRIC) DAY HEALTH CARE ACTIVITIES

Adult (geriatric) day health care activities provide health maintenance and therapeutic activities in a congregate setting for veterans who, without these activities, would require continued and full-time institutionalization. Advances in the understanding and treatment of certain illnesses of the elderly now make it possible for many of these persons to function independently with the partial care offered by these activities.

Staff in numerous VA medical centers have expressed strong interest in the potential for adult day health care in facilitating the return of older veterans to their own homes, to shorten the length of stay in acute beds, and to provide an activity at a VAMC, or supported by the VA in the community, in which these veterans can continue a preventive and therapeutic rehabilitation regimen.

VA is currently exploring the potential of adult day health care activities to provide a cost effective and appropriate level of care for selected patients.

RESIDENTIAL CARE (FORMERLY PERSONAL CARE HOME) PROGRAM

This is the largest of the extended care programs and is operated at minimal expense since the only cost to the VA is for administration. Care is provided in private homes selected by the VA, at the veteran's own expense. This residential care activity includes room, board, personal care, and general health care supervision to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable family resources to provide the needed care. All homes are inspected by a VA multidisciplinary team prior to incorporation into the program, and annually thereafter. Veterans receive monthly followup visits from VA social workers and other health care professionals, and are outpatients of the local VA facilities. In fiscal year 1982, an average daily census of 12,800 was maintained in this program utilizing approximately 3,124 homes.

STATE HOME PROGRAM

The State home program has grown from 11 homes in 11 States in 1888 to 45 State homes (one of which has two annexes) in 32 States and the District of Columbia. Currently, a total of 16,946 beds are authorized to provide hospital, nursing home, and domiciliary care.

The VA's relationship to State veterans' homes is based upon two grant programs. One is a per diem program which enables the VA to assist the States in providing care to veterans eligible for VA care who are furnished domiciliary, nursing home, or hospital care in State home facilities. The other grant program provides VA assistance with up to 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expansion, remodeling, or alteration of existing facilities.

In fiscal year 1982, the State home at Barboursville, W. Va., was established, and construction was started for the first State home in Maine. The VA also obligated $11.4 million in fiscal year 1982 for construction and renovation projects, including the first phase of a new State home for Maryland.

GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS (GRECC'S)

The GRECC program consists of eight centers and represents another aspect of the multifaceted VA response to the health care needs of aging veterans. It serves as a mechanism for attracting and developing superior staff into the field of gerontology and geriatrics. GRECC activities have been directed toward utilizing and redirecting existing resources for geriatric care, and advancing and integrating into the VA system clinical, research and educational achievement in geriatrics and gerontology. As a part of the program, GRECC's have developed geriatric evaluation units (GEU's), usually of 10 to 30 beds, for intensive diagnosis and therapy. Sic GRECC's have developed GEU's with a broad base in general internal medicine.

Each center typically emphasizes one area of research relevant to aging. For example, one center has developed a cardiopulmonary function evaluation unit, and five others, all with neuropsychiatric orientation, are focusing on chronic neurological diseases and organic dementias, including Alzheimer's type. GRECC professionals have produced well over 700 scientific publications since the beginning of the program in fiscal year 1975. GRECC's have reported the award of over $7 million in research funding during that same period. With the enactment of Public Law 96-330 and the creation of the Geriatrics and Gerontology Advisory Committee (GGAC), the GRECC's were formally evaluated during fiscal year 1982 by the committee through a site visit process. This report is due to the agency on April 1, 1983.

HOSPITAL BASED HOME CARE

This program allows for an early discharge of veterans with chronic illness to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital based multidisciplinary treatment team. The team provides the medical, nursing, social, rehabilitation, and dietetic regimens as well as the training of family members and the patient. Thirty VA medical centers are providing hospital based home care services. More acute care beds in hospitals are made available by providing increased days of care in the home.

In fiscal year 1981, 144,000 home visits were made by health professionals. Over 6,500 patients were treated, of which about 20 percent were terminal cancer patients. Eleven percent of these terminal patients died in their own homes while receiving support from the hospital based home care team.

III. MEDICAL SERVICE

In 1982, internists on both medical and intermediate care wards continued to be involved in providing care to elderly veterans with a wide variety of clinical problems. Where geriatric fellowship programs, GRECC's and geriatric evaluation units (GEU) exist, Medical Service physcians are active in these. Recently, hospital based home care initiated a senior clinician program in cooperation with Medical Service, Targeting some specific conditions such as chronic obstructive pulmonary disease (COPD), diabetes, and arthritis. Plans are underway to expand this. Medical Service has also worked closely with staff of the domiciliary program in helping to define models for delivery of medical care in domiciliaries. The VA has appointed a subcommittee to study and make recommendations on nutritional problems in the elderly. Treatment for high systolic hypertension in the elderly and its effect on mentation continues to be studied at several VA medical centers.

IV. MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

A focus on the mental health of the aging veteran is an important fact of the VA health care program. The Veterans Administration facilities for the care of older veterans are principally in the extended care programs, the Medical Service and the Psychiatry Service. Many of the patients in intermediate medical care and extended care facilities have a psychiatric diagnosis, as well as some physical disability. On a given day, the Medical Service in extended hospital care has about 9,340 patients (about 52 percent of these also have a psychiatric diagnosis). Of this group, 57 percent are 65 years of age or over. It should also be noted that some of the extended care programs report increasing number so admissions for long-term medical care directly from the community and not as transfers from one of the VA medical center wards or clinics.

Of the patients with a psychiatric diagnosis who are age 65 or older, 28 percent are on psychiatric wards and 72 percent are on other wards, principally long-term medicine. Many other older psychiatric patients are in VA and community nursing home facilities, VA domiciliaries, and residential care homes.

The Veterans Administration supports, through its research program, research on problems in long-term psychiatric disease, such as schizophrenia, Alzheimer's type senile dementia, and alcoholism, as well as other diseases common among aging individuals.

In March 1982, Mental Health and Behavioral Sciences Service conducted a survey of psychiatry and psychology services in VA medical centers to determine the extent of geriatric psychiatric programs. Of the 114 responses to the survey, 46 percent indicated they had initiated direct geriatric psychiatric services, including mental and/or neurological diagnosis and evaluation, individual therapy, family therapy, group therapy, and social and physical activities.

The VA has established geropsychiatric sections at its VA medical centers in Little Rock and North Little Rock, Ark.; Lyons, N.J.; Northport, N.Y.; Salisbury, N.C.; American Lake (Tacoma), Wash.; Brockton, Mass.; Coatesville, Pa.; Knoxville, Iowa; Los Angeles (Brentwood), Calif.; Murfreesboro, Tenn.; Salem, Va; Togus, Maine; and Waco, Tex. These sections emphasize attention to physical, mental, and social activity of a stimulating type. It is believed that some of these patients will make a better adjustment in the community and, with proper treatment, show improvement in their physical and mental state if kept physically and mentally active. Psychiatry also has geriatric day care programs at VA medical centers in Palo Alto, Calif.; North Chicago, Ill.; and Loma Linda, Calif.; and outpatient clinic, Boston, Mass. The number of geriatric day care programs is expected to increase as staff and support come available through redirection of existing resources in VA medical centers.

V. SOCIAL WORK SERVICE

The development of a full range of hospital and community based, cost-effective, health care services for the aging veterans is a priority of the Department of Medicine and Surgery, and a major responsibility of Social Work Service. The issue and challenge of this program responsibility was addressed in a national workshop entitled, "Community Options for the Aging Veteran," held in Washington, D.C., September 1982, and attended by social work resource staff representing 28 medical districts. The conference addressed organizational and clinical priority issues related to meeting the health care needs of the "at-risk" elderly. Issues identified and addressed during this conference included: Facilitating the discharge of older veterans with chronic health care problems into the community; expanding the range of community resources as alternatives to VA institutional care for the frail elderly; developing and coordinating plans for sharing appropriate community resources and services in support of VA health care goals; and developing a voluntary service network to extend VA and community services to enable the frail elderly to function as independently as possible. The development of a communications network among the 28 medical district representatives who attended the meeting was a significant outcome of the conference. In addition, a newsletter has been developed to share significant social work program developments and issues in the field of services to older veterans.

Social Work Service will sponsor a multidisciplinary workshop entitled, "The frail elderly veteran—an integrated approach to assessment, treatment, and the development of cost-effective alternatives to institutionalized care." This conference will be held in Florida in May 1983, and will emphasize the development of a VA/community service delivery model to meet the social and health care needs of older veterans. Medical district planning staff and representatives of community agencies will participate with VA health care staff in the development of a comprehensive service delivery model focused on the special needs of the elderly.

Chief Social Workers at VA medical centers in proximity to the sites have initiated contacts with Department of Health and Human Services demonstration project staffs to facilitate the coordination of services to the frail elderly by community agencies and VA social work staff. These projects are focused on accessing supportive services in the community to prevent unnecessary institutional care and improve coordination of services to frail, elderly veterans, and other citizens. The development of effective working relationships with community agency staff concerned with the development of services to the aging helps to prevent unnecessary duplication of services and makes better use of limited manpower resources.

Social Work Service is contributing to medical district initiated program planning (MEDIPP) in medical districts through membership on long-term care planning committees and participation on administrative planning boards. Social Work Service has actively supported establishment of multidisciplinary planning committees at medical centers in response to the Chief Medical Director's emphasis on developing medical center planning models to meet the needs of older veterans.

Social Work Service at each medical center is continuing to develop and expand its coordinating and resource function in meeting special needs of the elderly. Community resource directories have been developed at a number of medical centers to assist in the matching of community resources to patient needs. A computerized directory of community resources is under development in one medical district and should facilitate the discharge planning process for the impaired elderly and other "at risk" patients.

Volunteers are being used in some medical centers to maintain telephone contact with the frail elderly after a period of hospital care. This telephone reassurance program (Telecare) has proved to be of assistance in preventing the isolation of the elderly from those services that are needed.

In its role as a coordinator and broker of services between the VA health care system and community, Social Work Service directly impacts the efficiency of the VA system in meeting acute care needs of older veterans.

Experience with the DASH (day ambulatory services for health) program under the leadership of Social Work Service at the VA Medical Center in Loma Linda, Calif., suggests very strongly that the development of community based ambulatory health service models for the elderly has many advantages from a systems, patient care, and quality of life perspective. The elderly "at-risk" for institutional care are assisted in remaining in their own homes through the provision of appropriate health care services; quality of life, and level of satisfaction are improved, and, accordingly, services are provided at less cost for a broader population of those in need.

VI. Rehabilitation Medicine Service

Geriatric rehabilitation throughout the VA system appears to be a focal point not only of Rehabilitation Medicine Service, but also of many of the professional services which come into direct daily contact with this population. A "total rehabilitation" concept has welded the skills of the rehabilitation medicine therapist with the dietitian, the clinical psychologist, social workers, recreation specialists, clinical nursing specialists, and even the librarian in a multidisciplinary approach to improve the independence and well-being of the aging veteran. As evidenced in other medical treatment programs, the combined services of a variety of health care specialists significantly increase the quality of the overall treatment program.

Examples of this combined effort can be found at the VA's only independent domiciliary at White City, Oreg. All major medical specialty areas have focused on the elderly patient and have included the assistance of the engineering, chaplain, and fiscal services, to make life more accessible and meaningful for this increasing population. Local domiciliary management has deliberately drawn all programs together to serve the older veteran and coordinate the many treatment efforts that are needed in such a facility.

Occupational therapists at the VA Medical Center in Pittsburgh (Highland Drive), Pa., work closely with Dietetics and Nursing Services to organize "breakfast clubs" or institute simple cooking and baking classes specifically for the older veteran. Corrective therapists at the VA Medical Center in Temple, Tex., are combining with occupational therapy and Dietetics Service to provide a program of "Exercises for Mind and Body: Developing an Activity Class for the Institutionalized Elderly Resident." Community living skills training programs are being explored by the occupational therapy staffs at a number of VA medical centers, including Hampton, Va.; Knoxville, Iowa; Murfreesboro, Tenn.; Perry Point, Md.; San Diego, Calif.; and Waco, Tex.

A significant number of VA rehabilitation therapists are being included in continuing education courses, organized and supported by the VA's regional medical education centers, which focus on new and successful treatment programs for the geriatric population. VA central office staff are being included as speakers to emphasize the need for innovations in geriatric rehabilitation programs. The interest is improving VA-wide as Rehabilitation Medicine Service continues its commitment to the aging veteran.

VII. Nursing Service

Nursing services comprise the largest proportion of health care services required for the care of elderly veterans. As the clinical discipline with the major share of responsibility for coordinating programs for the aged veteran, Nursing Services are pursuing initiatives to develop innovative and comprehensive care delivery models for the management of patients with biophysical and psychosocial disturbances. Our efforts also involve a commitment to provide strong leadership in geriatric care at the central office level and the system as a whole.

In fiscal year 1982 central office Nursing Service implemented leadership training for supervisors of nursing home care units, and 10 nurses completed this preceptorship program. In-house nurse specialists in gerontology have been assigned servicewide responsibility to provide consultation on care planning and management of geriatric patients in both acute and long-term care settings, conduct inservice training on all aspects of patient care and conduct leadership seminars for head nurses.

The increasing demand for geriatric care has prompted more VA medical centers to expand their programs and establish geriatric evaluation and extended care units that are administered by nurses who are responsible for coordinating all of the care prescribed by various treatment services. The major components of care are patient assessment, health maintenance, prevention of illness, and health care training for patients and family members. Nursing care focuses on the rehabilitation process and incorporates sensory retraining, resocialization, physical fitness, reality approach to problems, remotivation and visuo-spatial learning. Several nurses conducted studies that addressed the role of geriatric nurse practitioners, effects of nursing interventions, and geriatric rehabilitation in these extended care modalities, and they have submitted their papers for publication in various professional journals.

Nursing has taken an active role in planning and providing expanded services to aging veterans. Two centers are developing proposals in collaboration with their affiliated colleges of nursing to establish a teaching nursing home model of care. Clinical specialists with masters degrees in gerontology, rehabilitation, and psychiatric nursing are participating in educational efforts within their respective medical districts and in regional medical education centers (RMEC's). Under Public Law 97-251, "VA Health Care Programs Improvement and Extension Act of 1982," permanently assigned employees who are enrolled in baccalaureate nursing programs will have an opportunity to apply for part-time VA scholarships. Nurses who complete these academic programs can be expected to provide valuable input in developing systemwide inpatient and ambulatory care programs for nursing care of the elderly. Alternative work schedules have also been proposed to attract and retain a larger number of knowledgeable and competent practitioners to the nursing services throughout the system.

There is an identified need to establish a network of nursing care services in the community for elderly veterans who are at high risk of being institutionalized. Model programs are demonstrating the valuable contribution of nursing support in the areas of health maintenance and health instruction to patients and caregivers in the home. Improvement and expansion of community services are essential to bridge the gap that exists and to allow frail elderly veterans to live in their own homes. Nurses are capable of assuming leadership for coordinating a large portion of health care services in the community.

Nursing Service is committed to its responsibilities and obligations as the major provider of health care, and will continue in its efforts to assure the quality, cost-effectiveness, and positive outcomes of long-term nursing care in the inpatient, ambulatory, and community care programs.

VIII. DIETETIC SERVICE

The nutrition component of the veteran's treatment becomes increasingly important as the veteran ages. Geriatric veterans are particularly vulnerable to nutrition problems and have a high potential for nutritional risk. The Dietetic Service in each VA medical center is headed by a qualified dietitian with a strong nutrition orientation. This assure excellent administrative support to meet aged veterans' nutritional needs as identified by the clinical dietitians responsible for the veterans' nutritional care. Studies have been conducted at VA medical centers to determine foods and menus most acceptable to geriatric patients who are subject to problems with chewing, swallowing, and consuming sufficient food for a nutritionally adequate diet. The environment for the long-term care geriatric patient influences normal social interaction and meal satisfaction. Dining room/recreation areas are planned in all long-term care facilities, such as nursing home care units and geropsychiatric units to prevent loss of social skills and to encourage normal social behavior and positive response to meals.

Clinical dietitians are members of multidisciplinary teams responsible for those programs which have a high geriatric patient population, e.g., nursing home care units, geropsychiatric units, domiciliaries, residential care programs, and alcohol treatment units. The employment of dietetic technicians who have completed

American Dietetic Association approved courses in nutritional care is encouraged for these geriatric programs. These clinical supportive personnel would enable more of the highly qualified clinical dietitians' time to be directed to geriatric and other age groups of veterans' acute nutrition problems. Nutrition education programs for geriatric patients could be expanded with the assistance of dietetic technicians.

Clinical dietitians have participated in providing geriatric nutrition education courses given under the sponsorship of VA-RMEC's, as well as community dietetic/nutrition associations. One of the first VA pilot tested educational teleconference programs was on the subject of geriatric nutrition. Over 100 dietitians in more remote VA locations were able to take advantage of this educational opportunity. VA dietitians continue to update themselves in the knowledge and skills required to manage the complex responsibilities of geriatric veterans' nutritional care.

IX. VOLUNTARY SERVICE

Throughout the VA medical care system, volunteers are active in community care, an aspect of treatment involving a high ratio of the elderly. Depending on their qualifications and the needs of the local situation, volunteer activities range from simple visits to veterans in contract nursing homes or contributions of comfort items and recreation materials, to service as members of the VA medical center teams inspecting and reporting on nursing homes or personal care homes. In addition to on-site visits, many medical facilities also have telecare programs in which volunteers keep in regular contact by telephone with patients living at home or in foster care facilities.

Adopt-a-grandparent programs, under a variety of names, are very popular and continue to spread through cooperative arrangements with schools and school systems. They involve visits on a regular schedule to VA nursing home care units and domiciliaries by groups of children and teenagers (preschool through high school) for group entertainment and one-to-one visits with the residents, whom most of them call "my guy."

Volunteers work with the older patients very helpfully in physical and occupational therapy, speech therapy, counseling, and other established treatment programs. At one medical center, they have been coteachers and therapist assistants on the geriatric ward in the Michigan program of retraining the aged veteran. At another, they are operating a sensory stimulation center (touching, feeling, seeing, smelling) where they work with the elderly. In Bath, N.Y., Literary Volunteers of America recruited from the local library have trained domiciliary members to teach reading to patients at the medical center. In Leavenworth, Kans., the VA medical center involves domiciliary members in volunteering to assist older people from the community in small work projects, a program operated in conjunction with the area agency on aging.

It is estimated that about one-third of the volunteers serving VA patients are over age 65. Overall, their effectiveness and dependability and the value of volunteering as an activity beneficial to themselves as well as to the patients has led the VA to continuing efforts to recruit individuals of retirement age. Currently, these efforts are concentrated nationally on the involvement of members of the American Association of Retired Persons as VA volunteers. A second group showing increased activity is the Telephone Pioneers of America.

X. DENTISTRY

With recognition of the ever-increasing age of the population served by the Veterans Administration, the VA Dental Service has turned its attention to the dentooral problems that face the aging veteran, and committed a major effort to caring for them. In doing so, it has recognized that many of the overt dental problems are not necessarily unique to geriatric patients and that technical procedures will not vary greatly from those used to treat other age groups. There are, however, many differences that must be appreciated by those treating older veterans, and by those who are planning for their care. For example, the incidence of oral diseases, ranging from periodontitis to cancer, significantly increases with age; many are totally or partially edentulous with detrimental effects on digestion, nutrition, and the ability to eat an interesting, palatable diet; many suffer from chronic dental pain and/or infection with no means to seek or receive private professional care; and self-image/self-acceptance factors are negatively affected in many elderly having poor or unreplaced missing teeth.

Dental treatment must often be modified because of advanced age or intercurrent systemic disease. For a number of reasons, elderly patients usually must have shorter appointments. Many geriatric patients are receiving multiple medications from their physicians and, thus, may have aberrant reactions to dental treatment or dentist prescribed medications. The attitudes and emotional status of the elderly also must be of constant concern to the practitioners before, during, and after treatment.

For these and related reasons, the Veterans Administration is taking steps to assure that its dentists and dental staffs are prepared to meet the challenges of caring for the aging veteran. To this end, a number of continuing education courses in geriatric dentistry have been held during the year for dentists and dental auxiliaries. Seventeen of our Dental Services competed for the opportunity to conduct ongoing fellowship programs in geriatric dentistry. Five sites were approved and funded to initiate fellowships in July. Despite a relatively short application period, excellent candidates emerged for each of the programs and five outstanding young dentists began their 2-year training period during that month. At VA central office, dentistry continued to be represented as primary members of the Geriatric Steering Committee and the Geriatric Liaison Coordinating Committee.

XI. MEDICAL RESEARCH SERVICE

The Veterans Administration is the largest single dispenser of health care in this country and, as such, is involved with the care of some 25 million veterans. Of these, approximately 3 million are now 65 years old or over. By the year 2000, this population will have increased to 8 million. These numbers emphasize the need to plan how to deal with the considerable social, economic, and personal consequences of this graying of the population. The task at hand is to ensure that the elderly do more than just survive to advanced age. A much larger proportion of their extended lives must be made creative, productive, and of value to the individual and to society.

To this end, more knowledge of the medical and psychosocial problems of the elderly is required if the health and social welfare costs generated by this segment of the population are to be reduced. That is, if the physical and mental defects caused by disease in the aged are diminished, the need for medical and social services will be decreased, and if the socioeconomic status of the elderly is maintained at acceptable levels, it may be possible to prevent, stabilize, or partially reverse functional impairments frequently encountered in the aged, again lessening the need for Government supported medical and social intervention.

The Veterans Administration has long emphasized the health and social needs of the aging veteran and, as a result, has given strong support to research on the biological, clinical, and psychosocial aspects of aging. These efforts have been manifested in the establishment of geriatric research, education and clinical centers (GRECC's), the geriatric physician fellowship program, the interdisciplinary team training program in geriatrics, and in the assignment of high priorities to research on the biology of aging and the development of innovative health care delivery systems. Some results of this research are presented below.

BASIC SCIENCE STUDIES

VA Medical Center, Ann Arbor, Mich.—It was shown that there is an age related decline in the proteins secreted by the parotid salivary gland of the rat (S-K. Kim). Among the proteins secreted by the salivary glands are antibodies and digestive enzymes. This suggests that some of the digestive problems and the decline in oral resistance to infections noted in the elderly may be caused, in part, by this loss of salivary gland function.

VA Medical Center, Bedford, Mass.—It was shown in non-human primates that antibodies which react with brain cells increase progressively in the serum with advancing age. However, the antibodies were already present in the youngest primates studied for 4 years (K. Nandy). The author suggests that the presence of these antibodies could be evidence of autoimmune reactions which might play a significant role in brain cell degeneration during aging. Mice placed on a vitamin E deficient diet developed learning defects and changes in the brain which were similar to those seen in senile dementia (K. Nandy). Thus, evidence continues to accumulate suggesting that establishing and maintaining the least body mass compatible with health at an early age leads to increased longevity and decreased health problems.

VA Medical Center, Decatur, Ga.—The ultraviolet (UV) component of sunlight is the primary stimulus for the majority of skin cancers. It was found that the incidence of US-induced cancers was the same in young and old mice. A vitamin A deficient diet increased the frequency of skin tumors (Z. H. Israill).

VA Medical Center, New Orleans, La.—Advancing age is associated with impaired alcohol metabolism in the rat. This results in exposure of the tissues of the elderly to higher levels of alcohol, as well as a prolonged exposure with any given dose (H. K. Kahn and H. E. Burch).

VA Medical Center, Palo Alto, Calif.—Pancreatic islets isolated from older rats are enlarged, their insulin content is increased, and they secrete more insulin in response to glucose stimulation. These changes could be inhibited by exercise training or caloric reduction (G. M. Reaven).

Studies were carried out in rates in an effort to define the mechanism by which plasma triglyceride levels increase with age. It was found that both triglyceride secretion and destruction increased with age, but that elevated levels developed because clearance mechanisms failed to keep pace with secretion rates (G. M. Reaven).

Elderly patients suffer from a high rate of adverse drug reactions. It has been shown in guinea pigs that, with aging, one commonly used psychotropic agent, chlorpromazine, is metabolized more slowly by the liver resulting in the presence of the drug in the blood for a prolonged period at higher levels (T. B. Okarma).

VA Medical Center, St. Louis, Mo.—It has been found that certain cell membranes become more fluid as a function of age, which results in changes in enzyme activity (H. J. Armbrecht).

It was found that the adult intestine responds to dietary vitamin 1, 25 (OH) D (activated vitamin D), but not a related compound 25-OH-D. Therefore, decreased calcium absorption by the adult may be due to a lack of the more active vitamin D itself, rather than to a decreased level of sensitivity to the vitamin (H. J. Armbrecht).

VA Medical Center, San Francisco, Calif.—It has been found that the liver enzyme NADPH cytochrome P-450 reduction undergoes age related alterations in its structure and/or composition which diminish its efficiency (D. L. Schmucher). This has relevance to the altered drug metabolism seen in the elderly.

VA Medical Center, Seattle, Wash.—It has been found in the aging rat that decreased plasma testosterone levels are the result of decreased testicular production in response to pituitary hormone stimulation which also decreases with age (D. M. Dorse).

VA Medical Center, (Wadsworth), Los Angeles, Calif.—Both hormonal and cell mediated immune responses decline with advancing age and, as a result, vulnerability to certain infectious, autoimmune, and neoplastic disease may increase. Work from the GRECC has show that: (1) Recovery of immunologic activities in old mice is delayed partly because of the inability of their stem cells to rapidly differentiate into mature cells (W. Peterson, et al.); (2) the age related decline in the ability of spleen T-cells to respond to stimulation is due to a reduced number of precursor units and reduced number of mature responder cells (W. Peterson); (3) T-cell growth factor decreases in old mice due to changes in helper T-cells and adherent cells (C. Mei-Ping and Makinodan); (4) the failure of spleen B-cells from old mice to respond to stimulation is due to suppressor cells which inhibit B-cell differentiation, but not B-cell proliferation (T. Makinodan); (5) old mice given grafts of young bone marrow and thymus respond better to immunological stimuli than do age-matched controls (T. Makinodan); and (6) the decline in immunological capacity seen in old mice is due in part to the inability of the thymus to generate different subpopulations of T-cells differentially (T. Makinodan).

Peripheral blood hemoglobin, white cell, and lymphocyte levels decrease significantly in healthy old mice. However, these old mice maintain their hemoglobin levels in the face of chronic blood loss, as well as do young mice. In addition, the old mice have as many marrow and spleen hematopoeitic precursors, before and after bleeding, as to the young animals (M. L. Tyan). Other studies suggest that the decline in blood lymphoctye counts, and to a lesser degree hemoglobin levels, are at least partially controlled by mechanisms intrinsic to the marrow itself (M. L. Tyan). The red blood cells of older mice become less resistant to oxidant damage which may contribute to the anemia seen in older animals (M. L. Tyan).

VA Medical Center, Wood, Wis.—There is a progressive decrease in sensitivity of the effect or thyroid hormone on Na+ <K+ATPase response in both the liver and kidney of aging rats. This may be related to the clinical entity of apathetic hyperthyroidism seen in the elderly (S. Gambert).

The total lymphocyte response to challenge with foreign antigen is reduced in elderly humans because, (a) fewer lymphocytes respond initially, and (b) fewer daughter cells are produced by each responding cell. This contributes significantly to the increased susceptibility to infection noted in the aged (P.G. Sohnie, et al.).

CLINICAL STUDIES

VA Medical Center, Albany, N.Y.—Thirty-nine male osteoporotic veterans were given multivitamins, calcium or calcitonin (a calcium regulatory hormone made in the thyroid gland). Preliminary date suggest that treatment with calcitonin, calcium and multivitamins can inhibit the bone loss normally seen in aging individuals and prevent at least some of the complications which result from this (S. Wallach). Osteoporosis is a problem of considerable magnitude. Approximately 7 million people in the United States are currently suffering from acute problems related to weakened vertebrae, and 8 million Americans have chronic problems related to osteoporosis of the spine. Osteoporosis is the major cause of hip fracture in the elderly.

VA Medical Center, Albuquerque, N. Mex.—Twelve healthy adult males were fed 40 mg of zinc sulfate daily for 5 weeks. High-density liporprotein-cholesterol concentrations decreased by 25 percent. Other plasma lipid values did not decrease (P. L. Kooper, Jr.). High density lipoproteins tend to protect against arteriosclerotic changes. Therefore, these results suggest that diets high in zinc may have a nonbeneficial effect in arterial disease.

VA Outpatient Clinc, Boston Mass.—Plasma norepinephrine levels (an adrenaline-like hormone) increase to a greater degree in response to upright posture or sugar ingestion in elderly humans than in the young (J.B. Young, et al.). The full implications of this reflection of increased sympathetic nervous system activity is not clear at present.

It has been hypothesized that physically active men are biologically more youthful than inactive men. In the normative aging study it has been found that activity correlates with biological age even when physical health, weight, and educational attainment are held constant. However, no cause of effect relationship can be concluded from this cross-sectional analysis (G.A. Borkin and A. M. Norris).

In moving from reclining to an upright posture, the pituitary gland secretes increase amounts of vasopression (a substance which help to maintain adequate blood pressure). It has been found that failure to increase vasorpressin levels under these conditions in more common in the elderly, which may contribute to their tendency to fall or faint after assuming an upright posture (J. W. Rowe, et al.).

A study contrasted the recall and recognition performance of young and old adults following intentional and incidental learning (reading a story). The large age-related deficit found in intentional recall was virtually eliminated in incidental recognition. Reading apparently induces a sufficient dept of processing to overcome memory loss (J. Cerelia, et al.).

Young individuals reach a state of mental alertness more quickly than do the elderly, and while feedback has an altering effect for the younger person, it has no such effect on the elderly (J. L. Fozard). That is, the slower reaction time of the elderly to stimuli, such as a change in a traffic light, appears to be relatively fixed. The rate of decline of lung function found in the older smoker lessens significantly when smoking is stopped (R. Bosse).

VA Medical Center, Buffalo, N.Y.—Successful control of blood pressure through drug therapy can reduce morbidity and mortality in the elderly. However, age-related factors also make this group prone to adverse side effects (B. K. Hookerjee, et al.).

VA Medical Center, Hampton, Va.—The nutritional status of 152 consecutive admissions was evaluated. Malnutrition was found in 40.8 percent of the patients. Malnutrition was more prevalent in patients over 65, but not in alcoholics (R. A. Biens).

VA Medical Center, Houston, Tex.—A noninvasive method of measuring regional blood flow in the brain has been developed using inhaled xenon and CAT scanning. This greatly reduces the risk to the patient because arteriography, an invasive technique, may no longer be required to obtain the same information. When using this method, it has been found that cerebral blood flow decreases with age and there is a parallel decrease in gray matter and vascular responsiveness (J. S. Meyer).

VA Medical Center, Lexington, Ky.—It has been postulated that Alzheimer's disease, a common and severe form of dementia, may be caused by the accumulation of aluminum in the brain. In a study of 14 confirmed cases of Alzheimer's disease and 28 nondemented control patients, no significant difference in brain aluminum was found between the two groups (W. R. Markesberry).

VA Medical Center, Milwaukee, Wis.—A yearly physical examination is required for all residents of VA nursing home care units. The cost is considerable. It was found that in an academically affiliated VA nursing home care unit with an ongoing geriatric educational program, the yearly examination revealed very few previously unknown abnormalities and, therefore, may be unnecessary (S. R. Gambert, et al.).

VA Medical Center, Minneapolis, Minn.—Studies on Parkinson's disease suggest that the motor symptom associated with dementia in this disease is slow reaction time rather than rigidity. Hypertension appears to act independently, producing deficits in memory and speed (J. A. Mortimer).

VA Medical Center, Murfreesboro, Tenn.—Bran cereal has been found to be an efficacious and cost effective substitute for laxatives in hospitalized elderly patients (E. H. Battle and C. E. Hanna).

VA Medical Center, St. Louis, Mo.—Studies of the changes that occur with age-related hearing loss indicate that individuals with more severe losses were less alert to information from the environment, less capable of memory tasks and learning new material, more paranoid, depressed, and perceived themselves to be experiencing more problems in coping with the environment. These results point up the need to discover and rehabilitate hearing loss early (C. J. Dye).

VA Medical Center, Salt Lake City, Utah.—Pattern flash was used to elicit visually evoked brain waves from 220 healthy males aged 4 to 90 years. It was found that these evoked brain waves were generally larger in the very young and old, suggesting that there is decreased cortical inhibition in these two groups (R. E. Dustman and E. W. Snyder).

VA Medical Center, San Diego, Calif.—After 7 days in culture, blood from old individuals contains fewer antibody producing cells than does blood from the young. Total T-lymphocytes were similar in both young and old, but T-helper cells were markedly increased in the aged (J. W. Hollingsworth).

VA Medical Center, San Francisco, Calif.—Sleep brain waves are markedly altered in the elderly. The clinical correlates of these changes need to be investigated (I. Feinberg).

VA Medical Center, Seattle, Wash.—Plasma norepinephrine levels are higher in healthy old men than in young men throughout the 24-hour day cycle and this correlates positively with blood pressure and degree of impairment of sleep pattern. Healthy old men have a greater increase of plasma norepinephrine during a standardized mental stress procedure. The metabolic clearance rate of epinephrine was found to be greater in old than in young individuals, suggesting that the production rate of epinephrine increases with age. (J. B. Halter).

In studies on the mechanism of decreased sugar tolerance in the aged, it was found that: (1) There is a decrease in calorie and carbohydrate intake in the elderly; (2) fat cell volumes are generally larger in the elderly; (3) peripheral insulin resistance is present in the elderly; and (4) the insulin producing cells are less sensitive especially during a low carbohydrate diet (M. Chen).

VA Medical Center, (Wadsworth), Los Angeles, Calif.—Systolic cardiac murmurs are common in the elderly. In the majority of cases this murmur is due to degenerative calcific valvular disease and in studies with normal and demented elderly individuals have suggested that P300, a long latency endogenous component of the auditory event-related brain wave, may be of diagnostic value in early dementia (K. Syndulko, et al.).

VA Medical Center, Wood, Wis.—Protein deficient diets are very common among the elderly, primarily for financial reasons. This type of dietary deficiency is difficult to diagnose but adds significantly to disease and disability (S. R. Gambert, et al.).

PSYCHOSOCIAL STUDIES

VA Medical Center, Bath, N.Y.—It was shown that among elderly veterans in a domiciliary setting, the stress of relocation is related to the degree of disruption of friendships, to the attitudes of the residents to the new location, and by the perceived ease of the relocation process (M. F. Nehrke). Behavioral observations of staff-resident verbal interactions confirmed the hypothesis that residents living on units with high staff-resident interaction perceived the environment as more congruent with their preferences than residents on units low in verbal interaction (D. J. Sperbeck, et al.). It was found that in the elderly, maintenance of accustomed levels of social interaction is related to subjective well-being (Tesch, Whithoume, and Nehrke).

VA Outpatient Clinic, Boston, Mass.—It was found that retirement did not result in an increase in the frequency of health complaints, and no increase in real health problems was noted in the retirees over the first three years (R. Bosse).

As individuals age, they often respond automatically to many situations despite the fact that a variety of choices are available. By requiring individuals to engage in choosing activities or to report about these, it was found that the elderly are able to sense the freedom and control which is available and this in turn motivates them and enhances their mental alertness (L. D. Perimuter).

XII. ACADEMIC AFFAIRS

Every short and long range plan of the VA's Department of Medicine and Surgery dealing with the health care needs of the Nation's growing population of elderly veterans includes Office of Academic Affairs sponsored or supervised health manpower training activities to help assure that the highest quality of geriatric care will be available to the aging patients who are eligible for the VA health care system.

The training of all categories of health care professionals for that purpose has always been a priority effort of every affiliation program carried out in VA medical centers and other health care facilities of the system. Work with geriatric patients is an inescapable and integral part of the clinical experience of the nearly 100,000 students and trainees—including 25,000 resident physicians—who work in those VA facilities each year as part of affiliation agreements between virtually all VA health care facilities and the nearly 1,000 health professional schools, colleges and university health science centers.

The Veterans Omnibus Health Care Act of 1976 (Public Law 94-581) and the National Academy of Sciences' 1977 report, "Study of Health Care for American Veterans," highlighted the significant role of the VA in providing leadership in geriatric training by noting that:

"The VA must prepare for large increases in the numbers of veterans eligible for and in need of long-term care. Alternative resources and programs of high quality are less available outside the VA. * * * In view of the fact that a higher quality of care is observed in VA hospitals with medical school affiliation, the VA should encourage the development of multidisciplinary geronotology and geriatric programs in the schools with which it affiliates. It is recommended that affiliations be encouraged with schools of medicine, nursing, social work, and allied health, and schools with programs in clinical psychology in which there are programs in gerontology and geriatrics."

The following special programs reflect some of the activities of the Department of Medicine and Surgery, Office of Academic Affairs, which have been responding to these needs:

GERIATRIC FELLOWSHIP PROGRAMS FOR PHYSICIANS

Medical educators are still debating whether or not geriatrics should be a separate specialty or a subspecialty in medicine, but the need for physicians with special training in geriatrics and gerontology is urgent in view of the rapidly increasing numbers of elderly veterans and aging Americans.

The VA health care system offers the clinical, rehabilitation, and followup patient care services, as well as research and multidisciplinary programs that provide the support elements required for the training of physicians in geriatrics. This special training is being accomplished through the VA geriatric fellowship program that has been in operation at 12 VA medical centers affiliated with medical schools since 1977-78.

The program is designed to develop a cadre of physicians capable of becoming directors and leaders of local and national geriatric medical programs. Their commitment to excellence in geriatric patient care is expected to permeate the teaching of medical students and house staff in order to foster positive reactions to this evolving area of medicine. The fellows' curriculum incorporates clinical, psycho-social, and educational resources related to the full continuum of treatment and health care of the elderly, but still allows modifications for personal research interests.

Over its 5-year history, the program has attracted physicians with high quality academic and professional backgrounds. Their genuine interests is the well-being of elderly veterans is apparent from the high retention rates of fellows in the 2-year program. Many of the fellows have published papers on geriatric topics in nationally recognized professional journals, and several fellows have authored or co-authored books on geriatrics and on medical ethics. Nearly a third of the 37 fellows who completed the program by June 1982 participated in international rotations in the United Kingdom, and a few presented papers in European geriatric conferences. Several former fellows were successful in national competitions and received important awards from the National Institute on Aging and the Henry J. Kaiser Family Foundation.

Of the three groups completing the geriatric fellowship program thus far (1980—8; 1981—13; 1982—16), about 75 percent remained in the VA system as full or part-time employees or consultants. More than 90 percent of the fellowship graduates continued in geriatric medicine. The demand for physicians specially trained in geriatrics increases each year, as evidenced by the multiple job offers extended to each fellow, not only from VA medical centers but also from private corporations and from medical schools.

DENTIST GERIATRIC FELLOWSHIP PROGRAM

In July 1982, a 2-year dentist geriatric fellowship program was started at five VA centers. This program is designed to fill similar needs in destistry that physician fellowship programs are already filling in medicine.

INTERDISCIPLINARY TEAM TRAINING

The interdisciplinary team training program has been activated at nine VA medical centers, six of which also have fellowship programs. The teams consist of physicians, nurses, psychologists, social workers, therapists, nutritionists, and other associated health professionals. Medical and associated health students rotate on the team.

The purpose of the interdisciplinary team training program include the development of a cadre of health practitioners with the knowledge and competencies required to provide interdisciplinary team care to meet the spectrum of health care and service needs of the aged veteran. The program serves as a model for VA staff development through regionally focused activities. Further, it provides leadership in interdisciplinary education for VA medical centers and health personnel to function collaboratively with physicians in caring for elderly veterans.

CLINICAL NURSE SPECIALIST

Clinical nurse training is another facet of VA education programs in geriatrics. The need for specially trained graduate level clinical nurse specialists is evidenced by the sophisticated level of care needed by the VA patient population, specifically in the area of geriatrics. Advanced nurse training is a high priority within the VA because of the shortage of such nursing specialists who are capable of assuming positions in specialized care and leadership. The clinical nurse specialist program was established in 1981 to attract clinical specialists to the VA and to meet staffing needs in priority areas in geriatrics, rehabilitation, and psychiatric/mental health, all of which impact on the care of the elderly veteran. Direct student support is provided to nurse specialist trainees for their clinical practicum at the Va medical centers affiliated with the academic institutions in which they are enrolled. In fiscal year 1982, 90 master's level clinical nurse specialist students were supported in 23 Va medical centers; 29 in geriatrics; 9 in rehabilitation; and 52 in psychiatric/mental health.

CONTINUING EDUCATION

Continuing and in-service education are offered by every VA facility according to identified needs, and geriatric related subjects are in great demand. In addition, regional programs on these subjects are presented by the seven regional medical education centers (RMEC's) for individuals from facilities within the region. Programs are also presented nationally for audiences drawn from the entire system.

Workshops, conferences, seminars, special experiences for professional staff members and staff teams are planned, conducted, and evaluated at the local medical center level by the regional medical education centers and by the VA central office. The programs are often conducted in cooperation with the geriatric research, education, and clinical centers (GRECC's). Examples of recent programs include:

—Interdisciplinary team approach for geriatrics care.
—Assessment of older patient.
—Growing old—why not, everyone else is.
—Geriatric patient in rehabilitation setting.
—Alternatives to traditional treatment in the care of the elderly.
—Dental management of the geriatric and medically compromised patient.

COOPERATIVE HEALTH MANPOWER EDUCATION PROGRAM

The eight VA cooperative health manpower education programs (CHEP, formerly AHEC) established over the last 10 years are also involved in geriatric education in a variety of ways in cooperation with community hospitals and educational institutions. Continuing education programs are conducted for various disciplines with particular emphasis on educational needs of both VA and contract community nursing home staffs. Seminars for large number of allied health personnel in the community are also held.

XIII. Department of Veterans Benefits

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits (pension, compensation, and dependency and indemnity compensation) administered by the Department of Veterans Benefits provide all or part of the income for 1,584,188 persons age 65 or older. This total includes 843,161 veterans, 649,478 widows, 75,817 mothers, and 15,732 fathers. Approximately 86,041 veterans age 78 or older receive a 25 percent differential in addition to their pension benefits under Public Law 86-211, as amended.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provided for a restructured pension program. Under this program eligible veterans receive a level of support meeting the national standard of need. Pensioners generally receive benefits equal to the difference between their annual income from all other sources and the appropriate income standard.

This act provided for an $1,202 increase in the applicable income standard for veterans of World War I or the Mexican border period. This provision was in acknowledgment of the special needs of our older veterans. Pensioners receiving benefits under the prior program were provided the opportunity to elect to receive benefits under the new program.

VETERANS ASSISTANCE SERVICE

Veterans Assistance Service personnel maintain liaison with nursing homes, senior citizen homes, and senior citizen centers in regional office areas. Locations are visited as the need arises. Appropriate pamphlets and application forms are provided to personnel at these homes during visits and through regular use of mailings. State and area agencies on aging (AAA) have been identified and are provided information on VA benefits and services through workshops and training sessions.

The Veterans Assistance Service exhibit, "Veterans Benefits for Older Americans," highlights, by pictures and accompanying text, the various benefits explained in the pamphlet of the same title (VA pamphlet 27-80-2). The exhibit, designed to convey the Veterans Administration's concern with the aging veteran population, has been displayed extensively at meetings addressing problems of the aging. The pamphlet was given wide distribution at the White House Conference on Aging, the National Council on Aging, and by information and referral representatives at field stations.

A videocassette containing information of special interest to older veterans has been produced and tested at selected field stations. The videotape is being edited based on the testing and will be available upon completion for use by senior citizen centers and similar community based information and referral agencies.

EDUCATIONAL ASSISTANCE

There are roughly 220 people age 65 or older receiving VA educational benefits, of whom fewer than 141 are training under chapter 34 of the Veterans Readjustment Act of 1966, as amended. Widows of veterans who died of service-connected causes, and wives of veterans who are permanently and totally disabled from service-connected disabilities total about 80 of the enrollees in the survivors' and dependents' educational assistance program. Last year, there were some 40 veterans, 65 years of age or older, participating in the vocational rehabilitation program. While no education service, vocational rehabilitation, or counseling service programs are specifically designed as a service to the aged, participation in the programs continues to include a small number of aged veterans and eligible dependents.

SUPPLEMENTAL MATERIAL

ELDERLY COMPOSITION OF THE POPULATION OF ALL U.S. STATES AND COUNTIES, 1980

Prepared by the Inter-University Consortium
for Political and Social Research at Ann
Arbor, Mich., from the 1980 Census of
Population and Housing, Summary Tape
File 1. The Committee Wishes To
Thank Dan Melnick and Eric
Austin for Making This
Data Available

14-968 O—83——19

AREA NAME ¦	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ALABAMA	609,114	15.6	440,015	11.3	278,382	7.1	127,614	3.3	34,019	0.9
AUTAUGA COUNTY	3,995	12.4	2,824	8.8	1,848	5.7	795	2.5	181	0.6
BALDWIN COUNTY	13,651	17.4	9,849	12.5	6,447	8.2	2,726	3.5	676	0.9
BARBOUR COUNTY	4,621	18.7	3,332	13.5	2,110	8.5	970	3.9	252	1.0
BIBB COUNTY	2,693	17.1	2,063	13.1	1,282	8.2	632	4.0	149	0.9
BLOUNT COUNTY	5,970	16.4	4,317	11.8	2,826	7.8	1,203	3.3	288	0.8
BULLOCK COUNTY	2,226	21.0	1,681	15.9	1,078	10.2	442	4.2	161	1.5
BUTLER COUNTY	4,611	21.3	3,432	15.8	2,060	9.5	1,053	4.9	319	1.5
CALHOUN COUNTY	16,511	13.8	11,609	9.7	7,562	6.3	3,235	2.7	812	0.7
CHAMBERS COUNTY	7,870	20.1	5,712	14.6	3,698	9.4	1,596	4.1	418	1.1
CHEROKEE COUNTY	3,289	17.5	2,338	12.5	1,519	8.1	646	3.4	173	0.9
CHILTON COUNTY	5,399	17.6	3,974	13.0	2,563	8.4	1,135	3.7	276	0.9
CHOCTAW COUNTY	2,792	16.6	2,111	12.5	1,305	7.7	657	3.9	149	0.9
CLARKE COUNTY	4,758	17.2	3,555	12.8	2,166	7.8	1,043	3.8	346	1.2
CLAY COUNTY	2,755	20.1	2,078	15.2	1,287	9.4	631	4.6	160	1.2
CLEBURNE COUNTY	2,205	17.5	1,593	12.6	974	7.7	493	3.9	126	1.0
COFFEE COUNTY	6,055	15.7	4,379	11.4	2,726	7.1	1,305	3.4	348	0.9
COLBERT COUNTY	8,763	16.1	6,113	11.2	3,847	7.1	1,780	3.3	486	0.9
CONECUH COUNTY	3,298	20.8	2,521	15.9	1,516	9.5	772	4.9	233	1.5
COOSA COUNTY	2,168	19.1	1,560	13.7	983	8.6	472	4.1	105	0.9
COVINGTON COUNTY	8,123	22.0	5,985	16.2	3,777	10.2	1,735	4.7	473	1.3
CRENSHAW COUNTY	3,128	22.2	2,358	16.7	1,453	10.3	688	4.9	217	1.5
CULLMAN COUNTY	10,782	17.5	7,780	12.6	4,955	8.0	2,227	3.6	598	1.0
DALE COUNTY	5,197	10.9	3,757	7.9	2,312	4.8	1,144	2.4	301	0.6
DALLAS COUNTY	8,851	16.4	6,679	12.4	4,084	7.6	1,982	3.7	613	1.1
DE KALB COUNTY	9,736	18.1	7,199	13.4	4,550	8.5	2,129	4.0	520	1.0
ELMORE COUNTY	6,842	15.8	4,939	11.4	3,063	7.1	1,437	3.3	439	1.0
ESCAMBIA COUNTY	6,299	16.4	4,660	12.1	2,914	7.6	1,360	3.5	386	1.0
ETOWAH COUNTY	18,483	17.9	13,104	12.7	8,522	8.3	3,705	3.6	877	0.9
FAYETTE COUNTY	3,659	19.5	2,722	14.5	1,748	9.3	771	4.1	203	1.1
FRANKLIN COUNTY	5,277	18.6	3,885	13.7	2,419	8.5	1,177	4.2	289	1.0
GENEVA COUNTY	4,784	19.7	3,530	14.6	2,274	9.4	1,023	4.2	233	1.0
GREENE COUNTY	2,250	20.4	1,790	16.2	1,100	10.0	538	4.9	152	1.4
HALE COUNTY	3,139	20.1	2,418	15.5	1,401	9.0	775	5.0	242	1.6
HENRY COUNTY	2,945	19.2	2,194	14.3	1,422	9.3	627	4.1	145	0.9
HOUSTON COUNTY	10,799	14.5	7,685	10.3	4,940	6.6	2,167	2.9	578	0.8
JACKSON COUNTY	7,313	14.2	5,187	10.1	3,363	6.5	1,486	2.9	338	0.7
JEFFERSON COUNTY	111,529	16.6	81,072	12.1	49,907	7.4	24,654	3.7	6,511	1.0
LAMAR COUNTY	3,200	19.4	2,406	14.6	1,520	9.2	722	4.4	164	1.0
LAUDERDALE COUNTY	12,441	15.4	8,775	10.9	5,555	6.9	2,497	3.1	723	0.9
LAWRENCE COUNTY	4,540	15.0	3,302	10.9	2,169	7.2	869	2.9	264	0.9
LEE COUNTY	8,029	10.5	5,634	7.4	3,664	4.8	1,547	2.0	423	0.6
LIMESTONE COUNTY	6,782	14.7	4,905	10.7	3,122	6.8	1,415	3.1	368	0.8
LOWNDES COUNTY	2,046	15.4	1,537	11.6	940	7.1	461	3.5	136	1.0
MACON COUNTY	4,864	18.1	3,635	13.5	2,192	8.2	1,061	4.0	382	1.4
MADISON COUNTY	21,089	10.7	14,232	7.2	9,314	4.7	3,898	2.0	1,020	0.5
MARENGO COUNTY	4,574	18.3	3,454	13.8	2,071	8.3	1,069	4.3	314	1.3
MARION COUNTY	5,495	18.3	4,071	13.6	2,604	8.7	1,190	4.0	277	0.9
MARSHALL COUNTY	11,099	16.9	7,909	12.1	5,022	7.7	2,311	3.5	576	0.9
MOBILE COUNTY	49,920	13.7	35,170	9.6	22,928	6.3	9,833	2.7	2,409	0.7
MONROE COUNTY	3,950	17.4	2,950	13.0	1,766	7.8	887	3.9	297	1.3
MONTGOMERY COUNTY	27,754	14.1	19,848	10.1	12,356	6.3	5,706	2.9	1,786	0.9
MORGAN COUNTY	12,929	14.3	9,024	10.0	5,877	6.5	2,504	2.8	643	0.7
PERRY COUNTY	2,949	19.6	2,285	15.2	1,377	9.2	700	4.7	208	1.4
PICKENS COUNTY	4,088	19.0	3,083	14.4	1,854	8.6	936	4.4	293	1.4
PIKE COUNTY	5,165	18.4	3,922	14.0	2,417	8.6	1,158	4.1	347	1.2
RANDOLPH COUNTY	4,096	20.4	3,029	15.1	1,857	9.3	935	4.7	237	1.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
RUSSELL COUNTY	7,187	15.2	5,014	10.6	3,411	7.2	1,264	2.7	339	0.7
ST. CLAIR COUNTY	5,978	14.5	4,176	10.1	2,691	6.5	1,181	2.9	304	0.7
SHELBY COUNTY	7,362	11.1	5,289	8.0	3,441	5.2	1,491	2.2	357	0.5
SUMTER COUNTY	3,146	18.6	2,437	14.4	1,479	8.7	745	4.4	213	1.3
TALLADEGA COUNTY	11,417	15.5	8,126	11.0	5,445	7.4	2,219	3.0	462	0.6
TALLAPOOSA COUNTY	7,383	19.1	5,355	13.8	3,369	8.7	1,553	4.0	433	1.1
TUSCALOOSA COUNTY	18,476	13.4	13,323	9.7	8,450	6.1	3,806	2.8	1,067	0.8
WALKER COUNTY	11,636	16.9	8,646	12.6	5,414	7.9	2,553	3.7	679	1.0
WASHINGTON COUNTY	2,477	14.7	1,820	10.8	1,123	6.7	537	3.2	160	1.0
WILCOX COUNTY	2,764	18.7	2,145	14.5	1,302	8.8	643	4.4	200	1.4
WINSTON COUNTY	3,512	16.0	2,528	11.5	1,651	7.5	712	3.2	165	0.8
ALASKA	19,643	4.9	11,547	2.9	8,312	2.1	2,616	0.7	619	0.2
ALEUTIAN ISLANDS CENSUS AREA	188	2.4	107	1.4	86	1.1	19	0.2	2	0.0
ANCHORAGE BOROUGH	6,590	3.8	3,520	2.0	2,623	1.5	741	0.4	156	0.1
BETHEL CENSUS AREA	684	6.2	431	3.5	314	2.9	102	0.9	15	0.1
BRISTOL BAY BOROUGH	47	4.3	25	2.3	17	1.6	7	0.6	1	0.1
DILLINGHAM CENSUS AREA	265	5.7	169	3.7	116	2.5	38	0.8	15	0.3
FAIRBANKS NORTH STAR BOROUGH	2,265	4.2	1,276	2.4	914	1.7	277	0.5	85	0.2
HAINES BOROUGH	143	8.5	78	4.6	67	4.0	10	0.6	1	0.1
JUNEAU BOROUGH	1,274	6.5	771	3.9	557	2.9	173	0.9	41	0.2
KENAI PENINSULA BOROUGH	1,480	5.5	827	3.3	633	2.5	170	0.7	24	0.1
KETCHIKAN GATEWAY BOROUGH	990	8.7	642	5.7	427	3.8	174	1.5	41	0.4
KOBUK CENSUS AREA	343	7.1	249	5.2	166	3.4	66	1.4	17	0.4
KODIAK ISLAND BOROUGH	452	4.5	255	2.6	179	1.8	65	0.7	11	0.1
MATANUSKA-SUSITNA BOROUGH	1,172	6.6	730	4.1	519	2.9	156	0.9	55	0.3
NOME CENSUS AREA	477	7.3	339	5.2	249	3.8	77	1.2	13	0.2
NORTH SLOPE BOROUGH	219	5.2	148	3.5	114	2.7	26	0.6	8	0.2
PRINCE OF WALES-OUTER KETCHIKA	246	6.4	151	4.0	98	2.6	38	1.0	15	0.4
SITKA BOROUGH	524	6.7	361	4.6	200	2.6	128	1.6	33	0.4
SKAGWAY-YAKUTAT-ANGOON CENSUS	280	8.1	192	5.5	126	3.6	56	1.6	10	0.3
SOUTHEAST FAIRBANKS CENSUS ARE	224	3.9	142	2.5	95	1.7	34	0.6	13	0.2
VALDEZ-CORDOVA CENSUS AREA	488	5.8	295	3.5	212	2.5	69	0.8	14	0.2
WADE HAMPTON CENSUS AREA	267	5.7	178	3.8	130	2.8	42	0.9	6	0.1
WRANGELL-PETERSBURG CENSUS ARE	554	9.0	353	5.7	244	4.0	83	1.3	26	0.4
YUKON-KOYUKUK CENSUS AREA	471	6.0	308	3.9	226	2.9	65	0.8	17	0.2
ARIZONA	431,762	15.9	307,362	11.3	202,120	7.4	85,364	3.1	19,878	0.7
APACHE COUNTY	4,017	7.7	2,810	5.4	1,743	3.3	767	1.5	300	0.6
COCHISE COUNTY	12,792	14.9	8,797	10.3	5,842	6.8	2,373	2.8	582	0.7
COCONINO COUNTY	5,428	7.2	3,553	4.7	2,362	3.1	927	1.2	264	0.4
GILA COUNTY	6,859	18.5	4,740	12.8	3,355	9.0	1,130	3.0	255	0.7
GRAHAM COUNTY	3,163	13.8	2,254	9.9	1,467	6.4	612	2.7	175	0.8
GREENLEE COUNTY	1,133	9.9	733	6.4	508	4.5	188	1.6	37	0.3
MARICOPA COUNTY	243,170	16.1	174,732	11.6	113,935	7.6	49,486	3.3	11,311	0.7
MOHAVE COUNTY	13,028	23.3	8,548	15.3	6,485	11.6	1,734	3.1	329	0.6
NAVAJO COUNTY	6,150	9.1	4,081	6.0	2,722	4.0	1,052	1.6	307	0.5
PIMA COUNTY	86,704	16.3	62,194	11.7	39,517	7.4	18,193	3.4	4,484	0.8
PINAL COUNTY	13,756	15.1	9,713	10.7	6,774	7.5	2,473	2.7	466	0.5
SANTA CRUZ COUNTY	2,743	13.4	1,904	9.3	1,260	6.2	502	2.5	142	0.7
YAVAPAI COUNTY	18,642	27.4	13,341	19.6	9,109	13.4	3,441	5.0	791	1.2
YUMA COUNTY	14,177	15.7	9,962	11.0	7,041	7.8	2,486	2.7	435	0.5
ARKANSAS	422,808	18.5	312,477	13.7	192,447	8.4	93,676	4.1	26,354	1.2
ARKANSAS COUNTY	4,723	19.5	3,421	14.2	1,979	8.2	1,108	4.6	334	1.4
ASHLEY COUNTY	4,581	17.3	3,409	12.8	2,068	7.8	1,016	3.8	325	1.2
BAXTER COUNTY	9,833	35.9	7,491	27.3	5,227	19.1	1,882	6.9	382	1.4
BENTON COUNTY	17,229	22.1	12,467	16.0	8,236	10.5	3,342	4.3	889	1.1
BOONE COUNTY	5,680	21.8	4,352	16.7	2,563	9.8	1,361	5.2	428	1.6
BRADLEY COUNTY	3,348	24.3	2,543	18.4	1,491	10.8	831	6.0	221	1.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 55-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
CALHOUN COUNTY	1,358	22.3	1,024	16.8	582	9.6	340	5.6	102	1.7
CARROLL COUNTY	4,126	25.5	3,062	18.9	1,879	11.6	946	5.8	237	1.5
CHICOT COUNTY	3,606	20.3	2,748	15.4	1,598	9.0	917	5.2	233	1.3
CLARK COUNTY	4,474	19.2	3,359	14.4	2,018	8.7	1,051	4.5	290	1.2
CLAY COUNTY	4,984	24.2	3,821	18.5	2,427	11.8	1,137	5.5	257	1.2
CLEBURNE COUNTY	4,136	24.5	3,034	17.9	2,053	12.1	784	4.6	197	1.2
CLEVELAND COUNTY	1,642	20.9	1,269	16.1	766	9.7	393	5.0	110	1.4
COLUMBIA COUNTY	5,536	20.8	4,230	15.9	2,456	9.2	1,373	5.2	401	1.5
CONWAY COUNTY	3,816	19.6	2,815	14.4	1,699	8.7	880	4.5	236	1.2
CRAIGHEAD COUNTY	9,539	15.1	6,912	10.9	4,324	6.8	1,993	3.2	595	0.9
CRAWFORD COUNTY	5,985	16.2	4,375	11.9	2,666	7.2	1,331	3.6	378	1.0
CRITTENDEN COUNTY	6,655	13.4	4,798	9.7	2,908	5.9	1,435	2.9	455	0.9
CROSS COUNTY	3,375	16.5	2,549	12.5	1,508	7.4	813	4.0	228	1.1
DALLAS COUNTY	2,372	22.6	1,794	17.1	1,046	9.9	578	5.5	170	1.6
DESHA COUNTY	3,593	18.2	2,709	13.7	1,604	8.1	835	4.2	270	1.4
DREW COUNTY	3,133	17.5	2,393	13.4	1,486	8.3	706	3.9	201	1.1
FAULKNER COUNTY	6,816	14.8	4,910	10.6	3,066	6.6	1,446	3.1	398	0.9
FRANKLIN COUNTY	3,093	21.0	2,354	16.0	1,391	9.5	719	4.9	244	1.7
FULTON COUNTY	2,603	26.1	1,938	19.4	1,218	12.2	558	5.6	162	1.6
GARLAND COUNTY	18,205	25.8	13,738	19.5	8,418	11.9	4,175	5.9	1,145	1.6
GRANT COUNTY	2,256	17.3	1,672	12.9	1,024	7.9	518	4.0	130	1.0
GREENE COUNTY	5,830	19.0	4,362	14.2	2,715	8.8	1,299	4.2	348	1.1
HEMPSTEAD COUNTY	5,318	22.5	4,008	17.0	2,466	10.4	1,186	5.0	356	1.5
HOT SPRING COUNTY	5,175	19.3	3,810	14.2	2,344	8.7	1,146	4.3	320	1.2
HOWARD COUNTY	3,084	22.9	2,365	17.6	1,376	10.2	729	5.4	260	1.9
INDEPENDENCE COUNTY	5,565	18.5	4,227	14.0	2,529	8.4	1,317	4.4	381	1.3
IZARD COUNTY	3,532	32.8	2,665	24.7	1,779	16.5	720	6.7	166	1.5
JACKSON COUNTY	4,329	20.0	3,205	14.8	2,028	9.4	952	4.4	225	1.0
JEFFERSON COUNTY	14,973	16.5	11,053	12.2	6,681	7.4	3,338	3.7	1,034	1.1
JOHNSON COUNTY	3,962	22.7	3,006	17.3	1,796	10.3	932	5.3	278	1.6
LAFAYETTE COUNTY	2,325	22.8	1,810	17.7	1,033	10.1	613	6.0	164	1.6
LAWRENCE COUNTY	4,140	22.4	3,103	16.8	1,906	10.3	934	5.1	263	1.4
LEE COUNTY	2,943	18.9	2,282	14.7	1,295	8.3	735	4.7	252	1.6
LINCOLN COUNTY	2,369	17.7	1,806	13.5	1,078	8.1	563	4.2	165	1.2
LITTLE RIVER COUNTY	2,433	17.4	1,841	13.2	1,104	7.9	558	4.0	179	1.3
LOGAN COUNTY	4,492	22.3	3,431	17.0	2,117	10.5	1,005	5.0	309	1.5
LONOKE COUNTY	5,400	15.6	4,007	11.6	2,431	7.0	1,215	3.5	361	1.0
MADISON COUNTY	2,388	21.0	1,774	15.6	1,082	9.5	550	4.8	142	1.2
MARION COUNTY	3,100	27.4	2,208	19.5	1,523	13.4	560	4.9	125	1.1
MILLER COUNTY	6,950	18.4	5,051	13.4	3,118	8.3	1,495	4.0	438	1.2
MISSISSIPPI COUNTY	8,971	15.1	6,564	11.0	4,176	7.0	1,877	3.2	511	0.9
MONROE COUNTY	3,015	21.5	2,251	16.0	1,345	9.6	719	5.1	187	1.3
MONTGOMERY COUNTY	1,939	25.0	1,459	18.8	920	11.8	435	5.6	104	1.3
NEVADA COUNTY	2,697	24.3	2,044	18.4	1,195	10.8	678	6.1	171	1.5
NEWTON COUNTY	1,443	18.6	1,032	13.3	685	8.8	278	3.6	69	0.9
OUACHITA COUNTY	6,625	21.7	4,902	16.1	3,000	9.8	1,512	5.0	390	1.3
PERRY COUNTY	1,448	19.9	1,053	14.5	669	9.2	313	4.3	71	1.0
PHILLIPS COUNTY	6,267	18.0	4,796	13.8	2,948	8.5	1,418	4.1	430	1.2
PIKE COUNTY	2,268	21.9	1,717	16.6	1,056	10.2	523	5.0	138	1.3
POINSETT COUNTY	4,761	17.6	3,464	12.8	2,218	8.2	986	3.6	260	1.0
POLK COUNTY	4,118	24.2	3,117	18.3	1,970	11.6	901	5.3	246	1.4
POPE COUNTY	6,339	16.2	4,607	11.8	2,779	7.1	1,405	3.6	423	1.1
PRAIRIE COUNTY	2,042	20.1	1,500	14.8	919	9.1	448	4.4	133	1.3
PULASKI COUNTY	46,588	13.7	33,215	9.8	20,031	5.9	10,240	3.0	2,944	0.9
RANDOLPH COUNTY	3,435	20.4	2,572	15.3	1,544	9.2	819	4.9	209	1.2
ST. FRANCIS COUNTY	5,026	16.3	3,704	12.0	2,281	7.4	1,108	3.6	315	1.0
SALINE COUNTY	6,962	13.1	4,851	9.1	3,136	5.9	1,339	2.5	376	0.7

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
SCOTT COUNTY	2,136	22.1	1,618	16.7	1,012	10.4	465	4.8	141	1.5
SEARCY COUNTY	2,034	23.0	1,501	17.0	916	10.4	454	5.1	131	1.5
SEBASTIAN COUNTY	16,589	17.4	12,085	12.7	7,259	7.6	3,701	3.9	1,125	1.2
SEVIER COUNTY	2,885	20.5	2,186	15.5	1,354	9.6	652	4.6	180	1.3
SHARP COUNTY	4,547	31.1	3,314	22.7	2,288	15.7	859	5.9	167	1.1
STONE COUNTY	1,905	21.1	1,390	15.4	867	9.6	414	4.6	109	1.2
UNION COUNTY	10,358	21.3	7,626	15.7	4,546	9.4	2,433	5.0	647	1.3
VAN BUREN COUNTY	3,449	25.8	2,381	17.8	1,652	12.4	573	4.3	156	1.2
WASHINGTON COUNTY	14,436	14.4	10,741	10.7	6,497	6.5	3,274	3.3	970	1.0
WHITE COUNTY	9,213	18.1	6,881	13.5	4,242	8.3	2,076	4.1	563	1.1
WOODRUFF COUNTY	2,433	21.7	1,844	16.4	1,110	9.9	593	5.3	141	1.3
YELL COUNTY	3,864	22.7	2,861	16.8	1,730	10.2	868	5.1	263	1.5
CALIFORNIA	3,406,678	14.4	2,414,250	10.2	1,470,978	6.2	725,255	3.1	218,017	0.9
ALAMEDA COUNTY	160,614	14.5	114,206	10.3	67,766	6.1	34,639	3.1	11,801	1.1
ALPINE COUNTY	102	9.3	58	5.3	38	3.5	18	1.6	2	0.2
AMADOR COUNTY	4,558	23.6	3,129	16.2	2,103	10.9	792	4.1	234	1.2
BUTTE COUNTY	30,487	21.2	22,251	15.5	13,983	9.7	6,370	4.4	1,898	1.3
CALAVERAS COUNTY	4,819	23.3	3,326	16.1	2,211	10.7	879	4.2	236	1.1
COLUSA COUNTY	2,368	18.5	1,690	13.2	994	7.8	510	4.0	186	1.5
CONTRA COSTA COUNTY	89,236	13.6	60,844	9.3	38,243	5.8	17,469	2.7	5,132	0.8
DEL NORTE COUNTY	3,184	17.5	2,208	12.1	1,452	8.0	623	3.4	133	0.7
EL DORADO COUNTY	12,863	15.0	8,498	9.9	5,907	6.9	2,093	2.4	498	0.6
FRESNO COUNTY	72,506	14.1	51,797	10.1	31,494	6.1	15,333	3.0	4,970	1.0
GLENN COUNTY	3,877	18.2	2,868	13.4	1,753	8.2	844	4.0	271	1.3
HUMBOLDT COUNTY	15,772	14.5	11,103	10.2	7,051	6.5	3,124	2.9	928	0.9
IMPERIAL COUNTY	12,005	13.0	8,330	9.0	5,536	6.0	2,305	2.5	489	0.5
INYO COUNTY	3,895	21.8	2,778	15.5	1,767	9.9	792	4.4	219	1.2
KERN COUNTY	56,275	14.0	39,227	9.7	25,731	6.4	10,806	2.7	2,690	0.7
KINGS COUNTY	8,938	12.1	6,370	8.6	3,939	5.3	1,856	2.5	575	0.8
LAKE COUNTY	11,264	31.0	7,960	21.9	5,459	15.0	2,027	5.6	474	1.3
LASSEN COUNTY	2,844	13.1	1,932	8.9	1,281	5.9	510	2.4	141	0.7
LOS ANGELES COUNTY	1,055,208	14.1	743,005	9.9	446,263	6.0	226,286	3.0	70,456	0.9
MADERA COUNTY	9,502	15.1	6,789	10.8	4,408	7.0	1,852	2.9	529	0.8
MARIN COUNTY	31,140	14.0	21,513	9.7	12,910	5.8	6,335	2.8	2,268	1.0
MARIPOSA COUNTY	2,447	22.0	1,718	15.5	1,125	10.1	470	4.2	123	1.1
MENDOCINO COUNTY	11,109	16.6	7,922	11.9	5,029	7.5	2,210	3.3	683	1.0
MERCED COUNTY	16,566	12.3	11,526	8.6	7,385	5.5	3,269	2.4	872	0.6
MODOC COUNTY	1,684	19.6	1,200	13.9	732	8.5	338	3.9	130	1.5
MONO COUNTY	591	6.9	365	4.3	265	3.1	92	1.1	8	0.1
MONTEREY COUNTY	37,742	13.0	26,750	9.2	16,467	5.7	7,943	2.7	2,340	0.8
NAPA COUNTY	20,296	20.5	15,028	15.1	8,711	8.8	4,706	4.7	1,611	1.6
NEVADA COUNTY	11,296	21.9	7,877	15.3	5,239	10.1	2,055	4.0	583	1.1
ORANGE COUNTY	229,921	11.9	160,913	8.3	94,456	4.9	51,460	2.7	14,997	0.8
PLACER COUNTY	18,510	15.8	13,097	11.2	8,231	7.0	3,768	3.2	1,098	0.9
PLUMAS COUNTY	2,981	17.2	1,990	11.5	1,370	7.9	474	2.7	146	0.8
RIVERSIDE COUNTY	133,651	20.2	98,737	14.9	61,794	9.3	29,691	4.5	7,252	1.1
SACRAMENTO COUNTY	108,122	13.8	74,489	9.5	46,451	5.9	21,664	2.8	6,374	0.8
SAN BENITO COUNTY	3,523	14.1	2,509	10.0	1,523	6.1	740	3.0	246	1.0
SAN BERNARDINO COUNTY	124,868	14.0	89,056	10.0	54,712	6.1	26,651	3.0	7,693	0.9
SAN DIEGO COUNTY	268,758	14.4	191,744	10.3	118,075	6.3	57,128	3.1	16,541	0.9
SAN FRANCISCO COUNTY	137,681	20.3	104,285	15.4	60,693	8.9	34,063	5.0	9,529	1.4
SAN JOAQUIN COUNTY	55,123	15.9	39,341	11.3	24,119	6.9	11,635	3.3	3,587	1.0
SAN LUIS OBISPO COUNTY	28,810	18.5	20,805	13.4	13,150	8.5	5,865	3.8	1,790	1.2
SAN MATEO COUNTY	90,788	15.5	62,048	10.6	38,972	6.6	17,743	3.0	5,333	0.9
SANTA BARBARA COUNTY	46,112	15.4	33,774	11.3	19,569	6.6	10,666	3.6	3,539	1.2
SANTA CLARA COUNTY	141,380	10.9	96,633	7.5	58,638	4.5	28,590	2.2	9,405	0.7
SANTA CRUZ COUNTY	32,736	17.4	24,898	13.2	14,088	7.5	8,150	4.3	2,660	1.4

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
SHASTA COUNTY	18,403	15.9	12,834	11.1	8,520	7.4	3,384	2.9	930	0.8
SIERRA COUNTY	633	20.6	442	14.4	310	10.1	111	3.6	21	0.7
SISKIYOU COUNTY	7,223	18.2	5,155	13.0	3,306	8.3	1,500	3.8	349	0.9
SOLANO COUNTY	26,075	11.1	17,932	7.6	11,403	4.8	5,147	2.2	1,382	0.6
SONOMA COUNTY	54,212	18.1	40,528	13.5	24,269	8.1	12,547	4.2	3,712	1.2
STANISLAUS COUNTY	40,403	15.2	29,183	11.0	17,836	6.7	8,690	3.3	2,657	1.0
SUTTER COUNTY	7,597	14.5	5,389	10.3	3,400	6.5	1,505	2.9	484	0.9
TEHAMA COUNTY	7,774	20.0	5,606	14.4	3,569	9.2	1,639	4.2	398	1.0
TRINITY COUNTY	2,011	17.0	1,324	11.2	923	7.8	327	2.8	74	0.6
TULARE COUNTY	36,335	14.8	26,325	10.7	16,700	6.8	7,507	3.1	2,118	0.9
TUOLUMNE COUNTY	6,708	19.8	4,674	13.8	3,194	9.4	1,177	3.5	303	0.9
VENTURA COUNTY	62,472	11.8	43,801	8.3	27,418	5.2	12,740	2.4	3,643	0.7
YOLO COUNTY	14,051	12.4	9,849	8.7	6,005	5.3	2,892	2.6	952	0.8
YUBA COUNTY	6,629	13.3	4,621	9.3	3,042	6.1	1,255	2.5	324	0.7
COLORADO	349,924	12.1	247,325	8.6	148,666	5.1	74,296	2.6	24,363	0.8
ADAMS COUNTY	20,474	8.3	13,130	5.3	8,520	3.5	3,529	1.4	1,081	0.4
ALAMOSA COUNTY	1,465	12.4	1,064	9.0	649	5.5	322	2.7	93	0.8
ARAPAHOE COUNTY	24,082	8.2	15,016	5.1	9,668	3.3	3,992	1.4	1,356	0.5
ARCHULETA COUNTY	523	14.3	339	9.3	230	6.3	88	2.4	21	0.6
BACA COUNTY	1,042	19.2	755	13.9	450	8.3	234	4.3	71	1.3
BENT COUNTY	1,196	20.1	886	14.9	516	8.7	271	4.6	99	1.7
BOULDER COUNTY	17,802	9.4	12,875	6.8	7,397	3.9	4,053	2.1	1,425	0.8
CHAFFEE COUNTY	2,090	15.8	1,552	11.7	975	7.4	441	3.3	136	1.0
CHEYENNE COUNTY	446	20.7	325	15.1	220	10.2	83	3.9	22	1.0
CLEAR CREEK COUNTY	657	9.0	434	5.9	270	3.7	136	1.9	28	0.4
CONEJOS COUNTY	1,156	14.8	832	10.7	518	6.6	251	3.2	63	0.8
COSTILLA COUNTY	605	19.7	415	13.5	237	7.7	130	4.2	48	1.6
CROWLEY COUNTY	803	26.9	605	20.2	333	11.1	204	6.8	68	2.3
CUSTER COUNTY	266	17.4	210	13.7	144	9.4	49	3.2	17	1.1
DELTA COUNTY	5,045	23.8	3,791	17.9	2,297	10.8	1,110	5.2	384	1.8
DENVER COUNTY	83,841	17.0	61,923	12.6	35,441	7.2	20,138	4.1	6,344	1.3
DOLORES COUNTY	264	15.9	173	10.4	119	7.2	44	2.7	10	0.6
DOUGLAS COUNTY	1,854	7.4	1,170	4.7	733	2.9	340	1.4	97	0.4
EAGLE COUNTY	617	4.6	398	3.0	278	2.1	90	0.7	30	0.2
ELBERT COUNTY	886	12.9	645	9.4	385	5.6	198	2.9	62	0.9
EL PASO COUNTY	30,786	9.9	21,056	6.8	12,936	4.2	6,140	2.0	1,980	0.6
FREMONT COUNTY	6,495	22.6	5,063	17.7	2,909	10.1	1,604	5.6	550	1.9
GARFIELD COUNTY	2,779	12.3	2,014	8.9	1,222	5.4	585	2.6	207	0.9
GILPIN COUNTY	221	9.1	162	6.6	109	4.5	46	1.9	7	0.3
GRAND COUNTY	578	7.7	365	4.9	271	3.6	75	1.0	19	0.3
GUNNISON COUNTY	688	6.4	497	4.6	304	2.8	150	1.4	43	0.4
HINSDALE COUNTY	40	9.8	28	6.9	19	4.7	6	1.5	3	0.7
HUERFANO COUNTY	1,567	24.3	1,185	18.4	684	10.6	384	6.0	117	1.8
JACKSON COUNTY	214	11.5	143	7.7	94	5.0	38	2.0	11	0.6
JEFFERSON COUNTY	33,693	9.1	22,086	5.9	13,892	3.7	6,083	1.6	2,111	0.6
KIOWA COUNTY	469	24.2	286	14.8	164	8.5	80	4.1	42	2.2
KIT CARSON COUNTY	1,408	18.5	1,047	13.8	637	8.4	290	3.8	120	1.6
LAKE COUNTY	546	6.2	360	4.1	283	3.2	62	0.7	15	0.2
LA PLATA COUNTY	3,371	12.3	2,369	8.6	1,483	5.4	677	2.5	209	0.8
LARIMER COUNTY	17,317	11.6	12,680	8.5	7,422	5.0	3,969	2.7	1,289	0.9
LAS ANIMAS COUNTY	3,477	23.3	2,645	17.8	1,555	10.4	812	5.5	278	1.9
LINCOLN COUNTY	1,106	23.7	816	17.5	459	9.8	249	5.3	108	2.3
LOGAN COUNTY	3,243	16.4	2,423	12.2	1,381	7.0	759	3.8	283	1.4
MESA COUNTY	11,960	14.7	8,735	10.7	5,087	6.2	2,726	3.3	922	1.1
MINERAL COUNTY	112	13.9	64	8.0	50	6.2	9	1.1	5	0.6
MOFFAT COUNTY	1,082	8.2	743	5.7	439	3.3	220	1.7	84	0.6
MONTEZUMA COUNTY	2,317	14.0	1,620	9.8	1,009	6.1	475	2.9	136	0.8

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
MONTROSE COUNTY	3,899	16.0	2,823	11.6	1,773	7.3	793	3.3	257	1.1
MORGAN COUNTY	3,809	16.9	2,851	12.7	1,614	7.2	927	4.1	310	1.4
OTERO COUNTY	4,389	19.4	3,328	14.7	1,859	8.2	1,090	4.8	379	1.7
OURAY COUNTY	326	16.9	225	11.7	163	8.5	53	2.8	9	0.5
PARK COUNTY	510	9.6	314	5.9	229	4.3	74	1.4	11	0.2
PHILLIPS COUNTY	1,107	24.4	856	18.8	474	10.4	294	6.5	88	1.9
PITKIN COUNTY	468	4.5	278	2.7	210	2.0	54	0.5	14	0.1
PROWERS COUNTY	2,167	16.6	1,586	12.1	895	6.8	492	3.8	199	1.5
PUEBLO COUNTY	20,445	16.2	14,569	11.6	9,064	7.2	4,188	3.3	1,317	1.0
RIO BLANCO COUNTY	613	9.8	420	6.7	269	4.3	107	1.7	44	0.7
RIO GRANDE COUNTY	1,842	17.5	1,390	13.2	798	7.6	426	4.1	166	1.6
ROUTT COUNTY	893	6.7	609	4.5	365	2.7	172	1.3	72	0.5
SAGUACHE COUNTY	641	16.3	469	11.9	290	7.4	143	3.6	36	0.9
SAN JUAN COUNTY	56	6.7	37	4.4	23	2.8	10	1.2	4	0.5
SAN MIGUEL COUNTY	241	7.6	177	5.5	116	3.6	47	1.5	14	0.4
SEDGWICK COUNTY	784	24.0	580	17.8	366	11.2	168	5.1	46	1.4
SUMMIT COUNTY	247	2.8	122	1.4	101	1.1	20	0.2	1	0.0
TELLER COUNTY	891	11.1	586	7.3	412	5.1	138	1.7	36	0.4
WASHINGTON COUNTY	1,087	20.7	793	15.0	460	8.7	255	4.8	78	1.5
WELD COUNTY	14,984	12.1	10,901	8.8	6,580	5.3	3,219	2.6	1,102	0.9
YUMA COUNTY	1,932	20.0	1,486	15.3	816	8.4	484	5.0	186	1.9
CONNECTICUT	521,534	16.8	364,864	11.7	219,717	7.1	109,418	3.5	35,729	1.1
FAIRFIELD COUNTY	133,509	16.5	92,120	11.4	56,194	7.0	26,941	3.3	8,985	1.1
HARTFORD COUNTY	137,599	17.0	96,221	11.9	57,192	7.1	29,363	3.6	9,666	1.2
LITCHFIELD COUNTY	28,588	18.2	20,512	13.1	12,510	8.0	6,062	3.9	1,940	1.2
MIDDLESEX COUNTY	21,589	16.7	15,226	11.8	9,163	7.1	4,601	3.6	1,462	1.1
NEW HAVEN COUNTY	137,510	18.1	96,792	12.7	57,977	7.6	29,309	3.8	9,506	1.2
NEW LONDON COUNTY	35,005	14.7	24,402	10.2	14,759	6.2	7,313	3.1	2,330	1.0
TOLLAND COUNTY	12,542	10.9	8,520	7.4	5,352	4.7	2,452	2.1	716	0.6
WINDHAM COUNTY	15,192	16.5	11,071	12.0	6,570	7.1	3,377	3.7	1,124	1.2
DELAWARE	86,009	14.5	59,179	10.0	36,630	6.2	17,280	2.9	5,269	0.9
KENT COUNTY	11,911	12.1	8,492	8.6	5,044	5.1	2,540	2.6	908	0.9
NEW CASTLE COUNTY	55,169	13.9	37,440	9.4	23,296	5.9	10,919	2.7	3,225	0.8
SUSSEX COUNTY	18,929	19.3	13,247	13.5	8,290	8.5	3,821	3.9	1,136	1.2
DISTRICT OF COLUMBIA	103,779	16.3	74,287	11.6	46,230	7.2	21,672	3.4	6,385	1.0
FLORIDA	2,252,225	[illegible]	1,687,573	17.3	1,059,153	10.9	511,078	5.2	117,342	1.2
ALACHUA COUNTY	15,051	[illegible]	10,747	7.1	6,812	4.5	3,104	2.1	831	0.5
BAKER COUNTY	1,848	[illegible]	1,340	8.8	860	[illegible]	372	2.4	108	0.7
BAY COUNTY	13,525	[illegible]	9,257	9.5	6,264	6.4	2,333	2.4	610	0.6
BRADFORD COUNTY	2,965	14.8	2,085	10.4	[illegible]	6.7	596	3.0	140	0.7
BREVARD COUNTY	50,875	18.6	34,666	12.7	23,877	8.7	8,678	3.2	2,111	0.8
BROWARD COUNTY	289,755	28.5	223,682	22.0	144,601	14.2	67,217	6.6	11,864	1.2
CALHOUN COUNTY	1,924	20.7	1,425	15.3	906	9.7	409	4.4	110	1.2
CHARLOTTE COUNTY	26,549	45.4	19,855	34.0	13,465	23.0	5,403	9.2	987	1.7
CITRUS COUNTY	21,428	39.2	15,870	29.0	11,200	20.5	3,906	7.1	764	1.4
CLAY COUNTY	6,948	10.4	4,931	7.4	2,951	4.4	1,469	2.2	511	0.8
COLLIER COUNTY	22,962	26.7	16,390	19.1	11,715	13.6	3,984	4.6	691	0.8
COLUMBIA COUNTY	5,156	14.6	3,595	10.2	2,309	6.5	1,018	2.9	268	0.8
DADE COUNTY	335,872	20.7	255,286	15.7	149,550	9.2	85,624	5.3	20,112	1.2
DE SOTO COUNTY	4,162	21.9	3,089	16.2	2,005	10.5	849	4.5	235	1.2
DIXIE COUNTY	1,418	18.3	937	12.1	641	8.3	247	3.2	49	0.6
DUVAL COUNTY	79,553	13.9	55,163	[illegible]	34,894	6.1	15,862	2.8	4,407	0.8
ESCAMBIA COUNTY	30,539	13.1	20,747	8.9	13,470	5.8	[illegible]	2.5	1,510	0.6
FLAGLER COUNTY	3,127	28.7	2,003	18.4	1,507	[illegible]	[illegible]	[illegible]	86	0.8
FRANKLIN COUNTY	1,558	20.3	1,145	14.9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.0
GADSDEN COUNTY	6,838	16.5	5,025	12.1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
GILCHRIST COUNTY	958	16.6	534	11.0	423	7.3	183	3.2	28	0.5
GLADES COUNTY	1,305	21.8	881	14.7	612	10.2	232	3.9	37	0.6
GULF COUNTY	1,754	16.5	1,209	11.3	822	7.7	318	3.0	69	0.6
HAMILTON COUNTY	1,546	17.6	1,159	13.2	745	8.5	316	3.6	98	1.1
HARDEE COUNTY	3,124	16.1	2,204	11.4	1,429	7.4	606	3.1	169	0.9
HENDRY COUNTY	2,391	12.9	1,600	8.6	1,104	5.9	408	2.2	88	0.5
HERNANDO COUNTY	15,602	35.1	10,853	24.4	7,818	17.6	2,507	5.6	528	1.2
HIGHLANDS COUNTY	16,319	34.3	12,527	26.4	8,053	16.9	3,750	7.9	724	1.5
HILLSBOROUGH COUNTY	103,243	16.0	74,313	11.5	46,465	7.2	22,020	3.4	5,828	0.9
HOLMES COUNTY	2,946	20.0	2,126	14.4	1,361	9.2	626	4.3	139	0.9
INDIAN RIVER COUNTY	16,654	27.8	12,180	20.3	8,079	13.5	3,375	5.6	726	1.2
JACKSON COUNTY	7,311	18.7	5,430	13.9	3,476	8.9	1,505	3.8	449	1.1
JEFFERSON COUNTY	1,932	18.1	1,418	13.2	830	7.8	477	4.5	111	1.0
LAFAYETTE COUNTY	681	16.9	491	12.2	314	7.8	137	3.4	40	1.0
LAKE COUNTY	34,311	32.7	26,640	25.4	17,130	16.3	7,834	7.5	1,676	1.6
LEE COUNTY	62,610	30.5	45,871	22.3	31,419	15.3	12,102	5.9	2,350	1.1
LEON COUNTY	14,390	9.7	9,764	6.6	6,306	4.2	2,704	1.8	754	0.5
LEVY COUNTY	4,403	22.2	3,103	15.6	2,108	10.6	778	3.9	217	1.1
LIBERTY COUNTY	735	17.3	516	12.1	344	8.1	150	3.5	22	0.5
MADISON COUNTY	2,874	19.3	2,119	14.2	1,372	9.2	572	3.8	175	1.2
MANATEE COUNTY	[illegible]0,844	34.3	40,156	27.1	23,719	16.0	13,272	8.9	3,165	2.1
MARION COUNTY	[illegible]	[illegible]	20,899	17.1	14,400	11.8	5,320	4.3	1,179	1.0
MARTIN COUNTY	20,782	32.[illegible]	[illegible],654	24.5	10,329	16.1	4,530	7.1	795	1.2
MONROE COUNTY	13,415	21.1	8,927	14.1	6,372	10.1	2,142	3.4	413	0.7
NASSAU COUNTY	3,816	11.6	2,549	7.7	1,760	5.4	638	1.9	151	0.5
OKALOOSA COUNTY	10,012	9.1	6,373	5.8	4,274	3.9	1,661	1.5	438	0.4
OKEECHOBEE COUNTY	3,526	17.4	2,451	12.1	1,743	8.6	596	2.9	112	0.6
ORANGE COUNTY	70,833	15.0	50,007	10.6	30,704	6.5	14,958	3.2	4,345	0.9
OSCEOLA COUNTY	11,520	23.4	8,749	17.8	4,936	10.0	2,937	6.0	876	1.8
PALM BEACH COUNTY	173,976	30.2	134,452	23.3	86,697	15.0	39,843	6.9	7,912	1.4
PASCO COUNTY	79,048	40.8	59,437	30.7	40,701	21.0	15,965	8.2	2,771	1.4
PINELLAS COUNTY	254,404	34.9	202,825	27.8	113,885	15.6	70,435	9.7	18,505	2.5
POLK COUNTY	62,572	19.5	46,033	14.3	29,141	9.1	13,551	4.2	3,341	1.0
PUTNAM COUNTY	10,934	21.6	7,659	15.2	5,166	10.2	2,029	4.0	464	0.9
ST. JOHNS COUNTY	10,472	20.4	7,501	14.6	4,697	9.2	2,155	4.2	649	1.3
ST. LUCIE COUNTY	20,626	23.7	14,797	17.0	10,060	11.5	3,867	4.4	870	1.0
SANTA ROSA COUNTY	6,000	10.7	4,072	7.3	2,759	4.9	1,062	1.9	251	0.4
SARASOTA COUNTY	77,750	38.4	60,609	30.0	37,887	18.7	18,884	9.3	3,838	1.9
SEMINOLE COUNTY	25,617	14.3	17,616	9.8	11,421	6.4	4,931	2.7	1,264	0.7
SUMTER COUNTY	5,666	23.3	4,054	16.7	2,801	11.5	1,038	4.3	215	0.9
SUWANNEE COUNTY	4,305	19.3	3,105	13.9	1,976	8.9	872	3.9	257	1.2
TAYLOR COUNTY	2,884	17.4	2,095	12.7	1,350	8.2	582	3.5	163	1.0
UNION COUNTY	921	9.1	609	6.0	391	3.8	171	1.7	47	0.5
VOLUSIA COUNTY	76,183	29.4	57,794	22.3	35,218	13.6	17,891	6.9	4,685	1.8
WAKULLA COUNTY	1,[illegible]	15.6	1,225	11.3	768	7.1	349	3.2	108	1.0
WALTON COUNTY	4[illegible]	22.0	3,395	15.9	2,213	10.4	936	4.4	246	1.2
WASHINGTON COUNTY	3,129	21.6	2,254	15.5	1,454	10.0	655	4.5	145	1.0
GEORGIA	732,600	13.4	516,731	9.5	330,874	6.1	146,423	2.7	39,434	0.7
APPLING COUNTY	2,241	14.4	1,607	10.3	1,027	6.6	462	3.0	118	0.8
ATKINSON COUNTY	956	15.6	673	11.0	469	7.6	173	2.8	31	0.5
BACON COUNTY	1,445	15.4	1,018	10.9	671	7.2	291	3.1	56	0.6
BAKER COUNTY	645	16.9	484	12.7	307	8.1	137	3.6	40	1.1
BALDWIN COUNTY	5,158	14.9	3,679	10.6	2,270	6.5	1,094	3.2	315	0.9
BANKS COUNTY	1,407	16.2	1,016	11.7	663	7.6	274	3.1	79	0.9
BARROW COUNTY	3,455	16.2	2,488	11.7	1,543	7.2	763	3.6	182	0.9
BARTOW COUNTY	5,730	14.1	4,009	9.8	2,688	6.6	1,064	2.6	257	0.6
BEN HILL COUNTY	3,030	18.9	2,229	13.9	1,452	9.1	622	3.9	155	1.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
BERRIEN COUNTY	2,260	16.7	1,548	11.4	990	7.3	460	3.4	98	0.7
BIBB COUNTY	23,026	15.3	16,148	10.7	10,337	6.9	4,601	3.1	1,210	0.8
BLECKLEY COUNTY	1,738	16.1	1,242	11.5	795	7.4	371	3.4	76	0.7
BRANTLEY COUNTY	1,102	12.7	795	9.1	556	6.4	203	2.3	36	0.4
BROOKS COUNTY	2,963	19.4	2,255	14.8	1,362	8.9	693	4.5	200	1.3
BRYAN COUNTY	1,124	11.0	752	7.4	534	5.2	174	1.7	44	0.4
BULLOCH COUNTY	4,885	13.7	3,516	9.8	2,258	6.3	991	2.8	267	0.7
BURKE COUNTY	3,150	16.3	2,287	11.8	1,378	7.1	717	3.7	192	1.0
BUTTS COUNTY	2,042	14.9	1,470	10.8	879	6.4	457	3.3	134	1.0
CALHOUN COUNTY	1,111	19.4	844	14.8	502	8.8	284	5.0	58	1.0
CAMDEN COUNTY	1,618	12.1	1,112	8.3	754	5.6	276	2.1	82	0.6
CANDLER COUNTY	1,657	22.0	1,223	16.3	774	10.3	362	4.8	87	1.2
CARROLL COUNTY	8,248	14.6	5,910	10.5	3,743	6.6	1,736	3.1	431	0.8
CATOOSA COUNTY	4,477	12.1	3,077	8.3	2,096	5.7	832	2.2	149	0.4
CHARLTON COUNTY	1,029	14.0	741	10.1	483	6.6	200	2.7	58	0.8
CHATHAM COUNTY	30,261	15.0	21,063	10.4	13,656	6.8	5,917	2.9	1,490	0.7
CHATTAHOOCHEE COUNTY	273	1.3	177	0.8	121	0.6	45	0.2	11	0.1
CHATTOOGA COUNTY	3,921	17.9	2,743	12.6	1,819	8.3	775	3.5	149	0.7
CHEROKEE COUNTY	5,771	11.2	4,133	8.0	2,614	5.1	1,191	2.3	328	0.6
CLARKE COUNTY	8,124	10.9	5,890	7.9	3,662	4.9	1,679	2.3	549	0.7
CLAY COUNTY	784	22.1	579	16.3	354	10.0	181	5.1	44	1.2
CLAYTON COUNTY	10,320	6.9	6,521	4.3	4,417	2.9	1,674	1.1	430	0.3
CLINCH COUNTY	962	14.4	655	9.8	418	6.3	195	2.9	42	0.6
COBB COUNTY	25,228	8.5	16,305	5.5	10,908	3.7	4,275	1.4	1,122	0.4
COFFEE COUNTY	3,955	14.7	2,771	10.3	1,899	7.1	720	2.7	152	0.6
COLQUITT COUNTY	6,127	17.3	4,369	12.4	2,864	8.1	1,225	3.5	280	0.8
COLUMBIA COUNTY	3,214	8.0	2,022	5.0	1,418	3.5	472	1.2	132	0.3
COOK COUNTY	2,291	17.0	1,620	12.0	1,048	7.8	458	3.4	114	0.8
COWETA COUNTY	6,033	15.4	4,297	10.9	2,798	7.1	1,178	3.0	321	0.8
CRAWFORD COUNTY	1,017	13.2	759	9.9	489	6.4	225	2.9	45	0.6
CRISP COUNTY	3,351	17.2	2,427	12.5	1,515	7.8	689	3.5	223	1.1
DADE COUNTY	1,568	12.7	1,064	8.6	675	5.5	299	2.4	90	0.7
DAWSON COUNTY	733	15.4	504	10.6	319	6.7	152	3.2	33	0.7
DECATUR COUNTY	4,234	16.6	3,074	12.1	1,971	7.7	858	3.4	245	1.0
DE KALB COUNTY	50,089	10.4	33,983	7.0	21,309	4.4	9,724	2.0	2,950	0.6
DODGE COUNTY	3,078	18.2	2,246	13.2	1,446	8.5	651	3.8	149	0.9
DOOLY COUNTY	2,039	18.8	1,491	13.8	928	8.6	451	4.2	112	1.0
DOUGHERTY COUNTY	10,718	10.6	7,300	7.2	4,716	4.7	2,020	2.0	564	0.6
DOUGLAS COUNTY	4,991	9.1	3,448	6.3	2,202	4.0	986	1.8	260	0.5
EARLY COUNTY	2,347	17.8	1,737	13.2	1,105	8.4	513	3.9	119	0.9
ECHOLS COUNTY	347	15.1	261	11.4	156	6.8	87	3.8	18	0.8
EFFINGHAM COUNTY	2,251	12.3	1,569	8.6	1,037	5.7	435	2.4	97	0.5
ELBERT COUNTY	3,443	18.4	2,534	13.5	1,599	8.5	726	3.9	209	1.1
EMANUEL COUNTY	3,677	17.7	2,632	12.7	1,749	8.4	703	3.4	180	0.9
EVANS COUNTY	1,482	17.6	1,089	12.9	695	8.2	326	3.9	68	0.8
FANNIN COUNTY	3,092	21.0	2,232	15.1	1,322	9.0	707	4.8	203	1.4
FAYETTE COUNTY	2,624	9.0	1,722	5.9	1,226	4.2	405	1.4	91	0.3
FLOYD COUNTY	13,336	16.7	9,510	11.9	6,250	7.8	2,573	3.2	687	0.9
FORSYTH COUNTY	3,478	12.4	2,353	8.4	1,603	5.7	600	2.1	150	0.5
FRANKLIN COUNTY	2,832	18.6	2,018	13.3	1,291	8.5	585	3.9	142	0.9
FULTON COUNTY	84,702	14.4	61,456	10.4	37,695	6.4	18,743	3.2	5,018	0.9
GILMER COUNTY	1,974	17.8	1,450	13.1	886	8.0	444	4.0	120	1.1
GLASCOCK COUNTY	552	23.2	405	17.0	244	10.2	115	4.8	46	1.9
GLYNN COUNTY	8,682	15.8	6,128	11.1	4,138	7.5	1,544	2.8	446	0.8
GORDON COUNTY	4,244	14.1	2,948	9.8	1,947	6.5	816	2.7	185	0.6
GRADY COUNTY	3,559	17.9	2,649	13.3	1,712	8.6	755	3.8	182	0.9
GREENE COUNTY	2,247	19.7	1,661	14.6	1,038	9.1	455	4.0	168	1.5

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
GWINNETT COUNTY	12,769	7.7	8,563	5.1	5,547	3.3	2,380	1.4	636	0.4
HABERSHAM COUNTY	3,882	15.5	2,738	10.9	1,740	7.0	785	3.1	213	0.8
HALL COUNTY	10,716	14.2	7,533	10.0	4,898	6.5	2,108	2.8	527	0.7
HANCOCK COUNTY	1,662	17.6	1,201	12.7	721	7.6	361	3.8	119	1.3
HARALSON COUNTY	3,118	16.9	2,299	12.5	1,475	8.0	624	3.4	200	1.1
HARRIS COUNTY	2,691	17.4	1,887	12.2	1,186	7.7	548	3.5	153	1.0
HART COUNTY	3,356	18.1	2,399	12.9	1,490	8.0	742	4.0	167	0.9
HEARD COUNTY	1,173	18.0	826	12.7	502	7.7	253	3.9	71	1.1
HENRY COUNTY	4,640	12.8	3,200	8.8	2,065	5.7	900	2.5	235	0.6
HOUSTON COUNTY	6,600	8.5	4,142	5.3	2,773	3.6	1,061	1.4	308	0.4
IRWIN COUNTY	1,746	19.4	1,265	14.1	810	9.0	355	3.9	100	1.1
JACKSON COUNTY	4,047	16.0	2,907	11.5	1,859	7.3	812	3.2	236	0.9
JASPER COUNTY	1,367	18.1	1,018	13.5	657	8.7	286	3.8	75	1.0
JEFF DAVIS COUNTY	1,615	14.1	1,149	10.0	778	6.8	300	2.6	71	0.6
JEFFERSON COUNTY	3,357	18.2	2,518	13.7	1,576	8.6	775	4.2	167	0.9
JENKINS COUNTY	1,479	16.7	1,060	12.0	694	7.8	288	3.3	78	0.9
JOHNSON COUNTY	1,660	19.2	1,218	14.1	765	8.8	334	3.9	119	1.4
JONES COUNTY	2,058	12.4	1,401	8.5	816	4.9	451	2.7	134	0.8
LAMAR COUNTY	2,097	17.2	1,535	12.6	977	8.0	421	3.4	137	1.1
LANIER COUNTY	866	15.3	672	11.9	450	8.0	177	3.1	45	0.8
LAURENS COUNTY	6,463	17.5	4,617	12.5	2,976	8.0	1,243	3.4	398	1.1
LEE COUNTY	1,147	9.8	757	6.5	515	4.4	199	1.7	43	0.4
LIBERTY COUNTY	2,013	5.4	1,300	3.5	863	2.3	316	0.8	121	0.3
LINCOLN COUNTY	1,157	17.2	807	12.0	549	8.2	204	3.0	54	0.8
LONG COUNTY	558	12.3	386	8.5	262	5.8	92	2.0	32	0.7
LOWNDES COUNTY	8,351	12.3	5,923	8.7	3,810	5.6	1,647	2.4	466	0.7
LUMPKIN COUNTY	1,448	13.5	1,069	9.9	667	6.2	288	2.7	114	1.1
MCDUFFIE COUNTY	2,674	14.4	1,859	10.0	1,246	6.7	460	2.5	153	0.8
MCINTOSH COUNTY	1,227	15.2	898	11.2	626	7.8	223	2.8	49	0.6
MACON COUNTY	2,409	17.2	1,766	12.6	1,053	7.5	550	3.9	163	1.2
MADISON COUNTY	2,487	14.0	1,759	9.9	1,220	6.9	452	2.5	87	0.5
MARION COUNTY	913	17.2	652	12.3	438	8.3	169	3.2	45	0.8
MERIWETHER COUNTY	3,620	17.1	2,604	12.3	1,670	7.9	722	3.4	212	1.0
MILLER COUNTY	1,323	18.8	965	13.7	619	8.8	288	4.1	58	0.8
MITCHELL COUNTY	3,262	15.4	2,343	11.1	1,501	7.1	667	3.2	175	0.8
MONROE COUNTY	2,399	16.4	1,772	12.1	1,072	7.3	537	3.7	163	1.1
MONTGOMERY COUNTY	1,151	16.4	845	12.1	551	7.9	244	3.5	50	0.7
MORGAN COUNTY	1,980	17.1	1,457	12.6	887	7.7	434	3.8	136	1.2
MURRAY COUNTY	2,159	11.0	1,518	7.7	1,018	5.2	421	2.1	79	0.4
MUSCOGEE COUNTY	22,016	12.9	15,144	8.9	10,050	5.9	4,044	2.4	1,050	0.6
NEWTON COUNTY	5,040	14.6	3,577	10.4	2,397	7.0	940	2.7	240	0.7
OCONEE COUNTY	1,460	11.7	1,057	8.5	648	5.2	337	2.7	72	0.6
OGLETHORPE COUNTY	1,464	16.4	1,062	11.9	664	7.4	317	3.6	81	0.9
PAULDING COUNTY	3,257	12.5	2,272	8.7	1,488	5.7	640	2.5	144	0.6
PEACH COUNTY	2,391	12.5	1,690	8.8	1,110	5.8	469	2.4	111	0.6
PICKENS COUNTY	2,092	18.0	1,523	13.1	946	8.1	455	3.9	122	1.0
PIERCE COUNTY	1,825	15.3	1,288	10.8	841	7.1	361	3.0	86	0.7
PIKE COUNTY	1,486	16.6	1,060	11.9	687	7.7	292	3.3	81	0.9
POLK COUNTY	5,957	18.4	4,296	13.3	2,838	8.8	1,187	3.7	271	0.8
PULASKI COUNTY	1,659	18.5	1,226	13.7	766	8.6	370	4.1	90	1.0
PUTNAM COUNTY	1,724	16.7	1,176	11.4	777	7.5	296	2.9	103	1.0
QUITMAN COUNTY	507	21.5	339	14.4	234	9.9	83	3.5	22	0.9
RABUN COUNTY	2,173	20.8	1,557	14.9	948	9.1	468	4.5	141	1.3
RANDOLPH COUNTY	2,048	21.3	1,559	16.2	958	10.0	468	4.9	133	1.4
RICHMOND COUNTY	21,963	12.1	15,243	8.4	9,714	5.3	4,356	2.4	1,173	0.6
ROCKDALE COUNTY	3,803	10.3	2,584	7.0	1,729	4.7	671	1.8	184	0.5
SCHLEY COUNTY	585	17.0	426	12.4	287	8.4	110	3.2	29	0.8

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
SCREVEN COUNTY	2,514	17.9	1,851	13.2	1,127	8.0	563	4.0	161	1.1
SEMINOLE COUNTY	1,671	18.4	1,203	13.3	789	8.7	352	3.9	62	0.7
SPALDING COUNTY	7,261	15.2	5,199	10.9	3,407	7.1	1,416	3.0	376	0.8
STEPHENS COUNTY	3,920	18.0	2,803	12.9	1,781	8.2	795	3.7	227	1.0
STEWART COUNTY	1,168	19.8	833	14.1	542	9.2	236	4.0	55	0.9
SUMTER COUNTY	4,881	16.6	3,664	12.5	2,067	7.0	1,135	3.9	462	1.6
TALBOT COUNTY	1,144	17.5	863	13.2	577	8.8	218	3.3	68	1.0
TALIAFERRO COUNTY	549	27.0	426	21.0	267	13.1	124	6.1	35	1.7
TATTNALL COUNTY	2,931	16.2	2,135	11.8	1,412	7.8	572	3.2	151	0.8
TAYLOR COUNTY	1,458	18.5	1,028	13.0	658	8.3	297	3.8	73	0.9
TELFAIR COUNTY	2,355	20.6	1,722	15.0	1,065	9.3	507	4.4	150	1.3
TERRELL COUNTY	2,145	17.8	1,560	13.0	979	8.1	443	3.7	146	1.2
THOMAS COUNTY	6,398	16.8	4,611	12.1	2,856	7.5	1,348	3.5	407	1.1
TIFT COUNTY	4,604	14.0	3,292	10.0	2,144	6.5	879	2.7	269	0.8
TOOMBS COUNTY	3,571	15.8	2,522	11.2	1,609	7.1	708	3.1	205	0.9
TOWNS COUNTY	1,341	23.8	951	16.9	621	11.0	255	4.5	75	1.3
TREUTLEN COUNTY	1,135	18.6	844	13.9	545	9.0	247	4.1	52	0.9
TROUP COUNTY	9,016	18.0	6,565	13.1	4,292	8.6	1,817	3.6	456	0.9
TURNER COUNTY	1,633	17.2	1,172	12.3	772	8.1	324	3.4	76	0.8
TWIGGS COUNTY	1,376	14.7	979	10.5	636	6.8	267	2.9	76	0.8
UNION COUNTY	1,897	20.2	1,429	15.2	834	8.9	462	4.9	133	1.4
UPSON COUNTY	5,176	19.9	3,755	14.4	2,451	9.4	1,064	4.1	240	0.9
WALKER COUNTY	8,918	15.8	6,225	11.0	3,981	7.0	1,773	3.1	471	0.8
WALTON COUNTY	4,693	15.0	3,376	10.8	2,136	6.8	947	3.0	293	0.9
WARE COUNTY	6,174	16.6	4,426	11.9	2,740	7.4	1,326	3.6	360	1.0
WARREN COUNTY	1,283	19.5	973	14.8	598	9.1	267	4.1	108	1.6
WASHINGTON COUNTY	3,244	17.2	2,415	12.8	1,471	7.8	714	3.8	230	1.2
WAYNE COUNTY	3,120	15.0	2,186	10.5	1,398	6.7	623	3.0	165	0.8
WEBSTER COUNTY	400	17.1	285	12.2	178	7.6	81	3.5	26	1.1
WHEELER COUNTY	1,034	20.1	760	14.7	476	9.2	236	4.6	48	0.9
WHITE COUNTY	1,808	17.9	1,307	12.9	811	8.0	373	3.7	123	1.2
WHITFIELD COUNTY	8,105	12.3	5,652	8.6	3,712	5.6	1,553	2.4	387	0.6
WILCOX COUNTY	1,605	20.9	1,176	15.3	710	9.2	373	4.9	93	1.2
WILKES COUNTY	2,180	19.9	1,587	14.5	989	9.0	466	4.3	132	1.2
WILKINSON COUNTY	1,576	15.2	1,126	10.9	747	7.2	319	3.1	60	0.6
WORTH COUNTY	2,778	15.4	1,997	11.1	1,302	7.2	553	3.1	142	0.8
HAWAII	113,944	11.8	76,150	7.9	49,375	5.1	21,214	2.2	5,561	0.6
HAWAII COUNTY	13,592	14.8	9,378	10.2	6,090	6.6	2,584	2.8	704	0.8
HONOLULU COUNTY	83,820	11.0	55,368	7.3	35,932	4.7	15,428	2.0	4,008	0.5
KALAWAO COUNTY	62	43.1	37	25.7	28	19.4	7	4.9	2	1.4
KAUAI COUNTY	6,125	15.7	4,339	11.1	2,810	7.2	1,237	3.2	292	0.7
MAUI COUNTY	10,345	14.6	7,028	9.9	4,515	6.4	1,958	2.8	555	0.8
IDAHO	131,877	14.0	93,680	9.9	58,292	6.2	26,912	2.9	8,476	0.9
ADA COUNTY	21,102	12.2	14,818	8.6	9,170	5.3	4,259	2.5	1,389	0.8
ADAMS COUNTY	587	17.5	415	12.4	254	7.6	129	3.9	32	1.0
BANNOCK COUNTY	7,454	11.4	5,221	8.0	3,258	5.0	1,511	2.3	452	0.7
BEAR LAKE COUNTY	1,159	16.7	835	12.0	469	6.8	278	4.0	88	1.3
BENEWAH COUNTY	1,269	15.3	903	10.9	584	7.0	243	2.9	76	0.9
BINGHAM COUNTY	4,268	11.7	2,973	8.1	1,956	5.3	789	2.2	228	0.6
BLAINE COUNTY	921	9.4	587	6.0	401	4.1	141	1.4	45	0.5
BOISE COUNTY	397	13.2	267	8.9	170	5.7	82	2.7	15	0.5
BONNER COUNTY	3,901	16.1	2,729	11.3	1,794	7.4	723	3.0	212	0.9
BONNEVILLE COUNTY	6,768	10.3	4,642	7.0	2,868	4.3	1,338	2.0	436	0.7
BOUNDARY COUNTY	1,104	15.1	824	11.3	499	6.8	244	3.3	81	1.1
BUTTE COUNTY	520	15.6	369	11.0	250	7.5	90	2.7	29	0.9
CAMAS COUNTY	121	16.0	99	12.1	74	9.0	20	2.4	5	0.6
CANYON COUNTY	13,586	16.2	9,866	11.8	5,929	7.1	2,967	3.5	970	1.2

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
CARIBOU COUNTY	949	10.9	660	7.6	434	5.0	170	2.0	56	0.6
CASSIA COUNTY	2,643	13.6	1,856	9.6	1,162	6.0	543	2.8	151	0.8
CLARK COUNTY	111	13.9	78	9.8	53	6.6	20	2.5	5	0.6
CLEARWATER COUNTY	1,460	14.1	1,002	9.6	671	6.5	251	2.4	80	0.8
CUSTER COUNTY	556	16.4	384	11.3	262	7.7	95	2.8	27	0.8
ELMORE COUNTY	1,730	8.0	1,133	5.3	731	3.4	313	1.5	89	0.4
FRANKLIN COUNTY	1,500	16.9	1,137	12.8	694	7.8	340	3.8	103	1.2
FREMONT COUNTY	1,452	13.4	1,043	9.6	683	6.3	295	2.7	65	0.6
GEM COUNTY	2,354	19.7	1,718	14.4	1,066	8.9	480	4.0	172	1.4
GOODING COUNTY	2,4[illegible]2	20.7	1,804	15.2	1,150	9.7	511	4.3	143	1.2
IDAHO COUNTY	2,524	17.1	1,841	12.5	1,153	7.8	546	3.7	142	1.0
JEFFERSON COUNTY	1,869	12.2	1,303	8.5	852	5.6	336	2.2	115	0.8
JEROME COUNTY	2,362	15.9	1,605	10.8	1,015	6.8	462	3.1	128	0.9
KOOTENAI COUNTY	9,190	15.4	6,533	10.9	4,129	6.9	1,840	3.[illegible]	564	0.9
LATAH COUNTY	3,578	12.4	2,677	9.3	1,488	5.2	830	2.9	359	1.2
LEMHI COUNTY	1,297	17.4	897	12.0	570	7.6	251	3.4	76	1.0
LEWIS COUNTY	772	18.7	566	13.7	342	8.3	184	4.5	40	1.0
LINCOLN COUNTY	602	17.5	438	12.7	280	8.1	119	3.5	39	1.1
MADISON COUNTY	1,423	7.3	1,015	5.2	622	3.2	300	1.5	93	0.5
MINIDOKA COUNTY	2,625	13.3	1,684	8.5	1,092	5.5	448	2.3	144	0.7
NEZ PERCE COUNTY	5,797	17.5	4,234	12.7	2,522	7.6	1,321	4.0	391	1.2
ONEIDA COUNTY	721	22.1	542	16.6	303	9.3	189	5.8	50	1.5
OWYHEE COUNTY	1,323	16.0	979	11.8	618	7.5	276	3.3	85	1.0
PAYETTE COUNTY	3,133	19.9	2,297	14.6	1,365	8.7	702	4.5	230	1.5
POWER COUNTY	814	11.9	550	8.0	363	5.3	135	2.0	52	0.8
SHOSHONE COUNTY	2,916	15.2	1,972	10.3	1,362	7.1	466	2.4	144	0.7
TETON COUNTY	398	13.7	274	9.5	182	6.3	75	2.6	17	0.6
TWIN FALLS COUNTY	9,403	17.8	6,881	13.0	4,178	7.9	2,038	3.9	665	1.3
VALLEY COUNTY	700	12.5	459	8.2	318	5.7	107	1.9	34	0.6
WASHINGTON COUNTY	2,046	23.2	1,570	17.8	956	10.9	455	5.2	159	1.8
ILLINOIS	1,772,117	15.5	1,261,885	11.0	761,483	6.7	385,720	3.4	114,682	1.0
ADAMS COUNTY	14,208	19.8	10,735	15.0	5,996	8.4	3,507	4.9	1,232	1.7
ALEXANDER COUNTY	2,934	23.9	2,236	18.2	1,376	11.2	681	5.6	179	1.5
BOND COUNTY	3,376	20.8	2,582	15.9	1,445	8.9	839	5.2	298	1.8
BOONE COUNTY	4,030	14.1	2,939	10.3	1,718	6.0	883	3.1	338	1.2
BROWN COUNTY	1,439	26.6	1,087	20.1	575	10.6	389	7.2	123	2.3
BUREAU COUNTY	8,320	21.3	6,183	15.8	3,597	9.2	1,980	5.1	606	1.5
CALHOUN COUNTY	1,407	24.0	1,097	18.7	678	11.6	321	5.5	98	1.7
CARROLL COUNTY	3,893	20.7	2,914	15.5	1,659	8.8	938	5.0	317	1.7
CASS COUNTY	3,081	20.4	2,354	15.6	1,271	8.4	776	5.1	307	2.0
CHAMPAIGN COUNTY	17,055	10.1	12,059	7.2	7,054	4.2	3,710	2.2	1,295	0.8
CHRISTIAN COUNTY	7,616	20.9	5,701	15.6	3,253	8.9	1,812	5.0	636	1.7
CLARK COUNTY	3,859	22.8	2,938	17.4	1,625	9.6	961	5.7	352	2.1
CLAY COUNTY	3,671	24.0	2,797	18.3	1,595	10.4	890	5.8	312	2.0
CLINTON COUNTY	5,362	16.4	3,986	12.2	2,310	7.1	1,312	4.0	364	1.1
COLES COUNTY	8,532	16.3	6,398	12.2	3,633	7.0	2,102	4.0	663	1.3
COOK COUNTY	819,948	15.6	572,453	10.9	355,273	6.8	170,283	3.2	46,897	0.9
CRAWFORD COUNTY	4,635	22.5	3,533	17.0	2,047	9.8	1,164	5.6	322	1.5
CUMBERLAND COUNTY	2,175	19.7	1,591	14.4	894	8.1	537	4.9	160	1.4
DE KALB COUNTY	9,122	12.2	6,447	8.6	3,705	5.0	2,020	2.7	722	1.0
DE WITT COUNTY	3,527	19.5	2,569	14.2	1,465	8.1	828	4.6	276	1.5
DOUGLAS COUNTY	3,610	18.3	2,623	13.3	1,518	7.7	829	4.2	276	1.4
DU PAGE COUNTY	68,310	10.4	45,471	6.9	27,916	4.2	13,358	2.0	4,197	0.6
EDGAR COUNTY	4,805	22.1	3,595	16.5	2,003	9.2	1,189	5.5	403	1.9
EDWARDS COUNTY	1,892	23.8	1,410	17.7	817	10.3	458	5.8	135	1.7
EFFINGHAM COUNTY	5,295	17.1	4,000	12.9	2,321	7.5	1,271	4.1	408	1.3
FAYETTE COUNTY	4,879	22.0	3,758	17.0	2,173	9.8	1,235	5.6	350	1.6

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
FORD COUNTY	3,283	21.5	2,446	16.0	1,321	8.7	826	5.4	299	2.0
FRANKLIN COUNTY	10,511	24.3	7,931	18.4	4,760	11.0	2,559	5.9	612	1.4
FULTON COUNTY	9,032	20.7	6,697	15.3	3,853	8.8	2,159	4.9	685	1.6
GALLATIN COUNTY	1,696	22.3	1,239	16.3	754	9.9	366	4.8	119	1.6
GREENE COUNTY	3,780	22.7	2,871	17.2	1,611	9.7	943	5.7	317	1.9
GRUNDY COUNTY	4,595	15.0	3,320	10.9	2,051	6.7	996	3.3	273	0.9
HAMILTON COUNTY	2,413	26.3	1,828	19.9	1,030	11.2	618	6.7	180	2.0
HANCOCK COUNTY	5,196	21.8	3,895	16.3	2,259	9.5	1,230	5.2	406	1.7
HARDIN COUNTY	1,262	23.4	898	16.7	538	10.0	288	5.4	72	1.3
HENDERSON COUNTY	1,643	18.0	1,183	13.0	724	7.9	369	4.0	90	1.0
HENRY COUNTY	10,305	17.8	7,594	13.1	4,355	7.5	2,417	4.2	822	1.4
IROQUOIS COUNTY	6,776	20.5	5,073	15.4	2,887	8.8	1,609	4.9	577	1.7
JACKSON COUNTY	8,138	13.2	6,068	9.9	3,613	5.9	1,840	3.0	615	1.0
JASPER COUNTY	2,407	21.3	1,831	16.2	976	8.6	658	5.8	197	1.7
JEFFERSON COUNTY	7,439	20.4	5,575	15.3	3,276	9.0	1,769	4.8	530	1.4
JERSEY COUNTY	3,342	16.3	2,418	11.8	1,385	6.7	765	3.7	268	1.3
JO DAVIESS COUNTY	4,273	18.2	3,054	13.0	1,782	7.6	985	4.2	287	1.2
JOHNSON COUNTY	2,051	21.3	1,529	15.9	956	9.9	426	4.4	147	1.5
KANE COUNTY	35,301	12.7	25,320	9.1	14,518	5.2	8,230	3.0	2,572	0.9
KANKAKEE COUNTY	15,644	15.2	11,099	10.8	6,846	6.7	3,305	3.2	948	0.9
KENDALL COUNTY	3,776	10.1	2,621	7.0	1,598	4.3	773	2.1	250	0.7
KNOX COUNTY	11,836	19.2	8,867	14.4	4,947	8.0	2,997	4.9	923	1.5
LAKE COUNTY	47,145	10.7	31,812	7.2	19,749	4.5	9,214	2.1	2,849	0.6
LA SALLE COUNTY	22,176	19.8	16,231	14.5	9,520	8.5	5,109	4.6	1,602	1.4
LAWRENCE COUNTY	4,266	24.0	3,256	18.3	1,788	10.0	1,075	6.0	393	2.2
LEE COUNTY	6,434	17.7	4,669	12.9	2,694	7.4	1,505	4.1	470	1.3
LIVINGSTON COUNTY	7,724	18.7	5,711	13.8	3,078	7.4	1,906	4.6	727	1.8
LOGAN COUNTY	6,209	19.5	4,695	14.8	2,582	8.1	1,545	4.9	568	1.8
MCDONOUGH COUNTY	5,826	15.5	4,381	11.7	2,394	6.4	1,495	4.0	492	1.3
MCHENRY COUNTY	18,995	12.8	13,511	9.1	8,264	5.6	4,085	2.8	1,162	0.8
MCLEAN COUNTY	15,806	13.3	11,554	9.7	6,569	5.5	3,703	3.1	1,282	1.1
MACON COUNTY	21,106	16.1	15,324	11.7	8,829	6.7	4,975	3.8	1,520	1.2
MACOUPIN COUNTY	10,763	21.8	8,141	16.5	4,502	9.1	2,675	5.4	964	2.0
MADISON COUNTY	40,986	16.5	29,261	11.8	17,824	7.2	8,989	3.6	2,448	1.0
MARION COUNTY	9,073	20.8	6,822	15.7	3,968	9.1	2,182	5.0	672	1.5
MARSHALL COUNTY	2,907	20.1	2,156	14.9	1,195	8.3	702	4.8	259	1.8
MASON COUNTY	3,686	18.9	2,733	14.0	1,617	8.3	850	4.4	266	1.4
MASSAC COUNTY	3,348	22.3	2,527	16.9	1,519	10.1	761	5.1	247	1.6
MENARD COUNTY	2,252	19.2	1,707	14.6	917	7.8	560	4.8	230	2.0
MERCER COUNTY	3,397	17.6	2,475	12.8	1,415	7.3	780	4.0	280	1.5
MONROE COUNTY	3,606	17.9	2,675	13.3	1,560	7.8	844	4.2	271	1.3
MONTGOMERY COUNTY	7,158	22.6	5,437	17.2	3,005	9.5	1,800	5.7	632	2.0
MORGAN COUNTY	7,195	19.2	5,421	14.5	2,997	8.0	1,808	4.8	616	1.6
MOULTRIE COUNTY	3,078	21.2	2,367	16.3	1,245	8.6	755	5.2	367	2.5
OGLE COUNTY	7,525	16.2	5,452	11.8	3,203	6.9	1,666	3.6	583	1.3
PEORIA COUNTY	32,233	16.1	23,534	11.7	13,985	7.0	7,383	3.7	2,166	1.1
PERRY COUNTY	4,547	20.9	3,477	16.0	1,956	9.0	1,167	5.4	354	1.6
PIATT COUNTY	2,850	17.2	2,056	12.4	1,165	7.0	659	4.0	232	1.4
PIKE COUNTY	4,611	24.4	3,523	18.6	1,991	10.5	1,141	6.0	391	2.1
POPE COUNTY	1,004	22.8	776	17.6	437	9.9	267	6.1	72	1.6
PULASKI COUNTY	2,142	24.2	1,664	18.8	957	10.8	532	6.0	175	2.0
PUTNAM COUNTY	989	16.3	698	11.5	434	7.1	216	3.5	48	0.8
RANDOLPH COUNTY	6,762	19.0	5,115	14.3	2,935	8.2	1,643	4.6	537	1.5
RICHLAND COUNTY	3,564	20.3	2,727	15.5	1,669	9.5	819	4.7	239	1.4
ROCK ISLAND COUNTY	27,152	16.4	19,338	11.7	11,768	7.1	5,797	3.5	1,773	1.1
ST. CLAIR COUNTY	40,703	15.2	29,245	10.9	17,897	6.7	8,759	3.3	2,589	1.0
SALINE COUNTY	7,340	25.8	5,659	19.9	3,316	11.7	1,811	6.4	532	1.9

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
SANGAMON COUNTY	28,905	17.0	22,037	12.5	13,277	7.5	6,817	3.9	1,943	1.1
SCHUYLER COUNTY	1,907	22.8	1,453	17.4	773	9.2	494	5.9	186	2.2
SCOTT COUNTY	1,404	22.9	1,064	17.3	595	9.7	358	5.8	111	1.8
SHELBY COUNTY	5,026	21.0	3,747	15.7	2,210	9.2	1,174	4.9	363	1.5
STARK COUNTY	1,596	21.6	1,180	16.0	665	9.0	388	5.3	127	1.7
STEPHENSON COUNTY	9,255	18.7	6,850	13.8	3,867	7.8	2,206	4.5	777	1.6
TAZEWELL COUNTY	17,586	13.3	12,515	9.5	7,664	5.8	3,778	2.9	1,073	0.8
UNION COUNTY	4,727	26.6	3,426	19.3	2,531	14.2	710	4.0	185	1.0
VERMILION COUNTY	17,226	18.1	12,471	13.1	7,334	7.7	3,926	4.1	1,211	1.3
WABASH COUNTY	2,670	19.5	1,974	14.4	1,176	8.6	616	4.5	182	1.3
WARREN COUNTY	4,257	19.4	3,235	14.7	1,747	8.0	1,095	5.0	393	1.8
WASHINGTON COUNTY	3,614	23.4	2,776	18.0	1,546	10.0	946	6.1	286	1.8
WAYNE COUNTY	4,303	23.8	3,227	17.9	1,863	10.3	1,046	5.8	318	1.8
WHITE COUNTY	4,480	25.1	3,408	19.1	1,952	10.9	1,095	6.1	361	2.0
WHITESIDE COUNTY	10,612	16.1	7,585	11.5	4,414	6.7	2,384	3.6	787	1.2
WILL COUNTY	34,345	10.6	23,982	7.4	14,828	4.6	7,072	2.2	2,092	0.6
WILLIAMSON COUNTY	11,554	20.4	8,562	15.1	5,007	8.9	2,812	5.0	743	1.3
WINNEBAGO COUNTY	36,204	14.4	25,593	10.2	15,006	6.0	7,945	3.2	2,642	1.1
WOODFORD COUNTY	5,158	15.5	3,845	11.5	2,127	6.4	1,279	3.8	439	1.3
INDIANA	819,166	14.9	585,384	10.7	350,458	6.4	180,515	3.3	54,410	1.0
ADAMS COUNTY	4,557	15.4	3,301	11.1	1,903	6.4	1,079	3.6	319	1.1
ALLEN COUNTY	39,456	13.4	28,074	9.5	16,479	5.6	8,888	3.0	2,707	0.9
BARTHOLOMEW COUNTY	8,160	12.5	5,767	8.9	3,496	5.4	1,713	2.6	558	0.9
BENTON COUNTY	2,040	20.0	1,491	14.6	847	8.3	483	4.7	161	1.6
BLACKFORD COUNTY	2,692	17.3	1,955	12.6	1,140	7.3	605	3.9	210	1.3
BOONE COUNTY	5,591	15.3	4,138	11.4	2,189	6.0	1,367	3.8	582	1.6
BROWN COUNTY	1,953	15.8	1,321	10.7	892	7.2	353	2.9	76	0.8
CARROLL COUNTY	3,505	17.8	2,516	12.8	1,417	7.2	840	4.3	259	1.3
CASS COUNTY	7,063	17.3	4,995	12.2	3,027	7.4	1,476	3.6	492	1.2
CLARK COUNTY	11,324	12.7	7,911	8.9	4,924	5.5	2,357	2.7	630	0.7
CLAY COUNTY	5,146	20.7	3,854	15.5	2,172	8.7	1,322	5.3	360	1.4
CLINTON COUNTY	5,995	19.0	4,475	14.2	2,344	7.4	1,552	4.9	579	1.8
CRAWFORD COUNTY	1,727	17.6	1,313	13.4	825	8.4	387	3.9	101	1.0
DAVIESS COUNTY	5,394	19.4	3,939	14.2	2,338	8.4	1,210	4.3	391	1.4
DEARBORN COUNTY	5,133	15.0	3,699	10.8	2,193	6.4	1,160	3.4	346	1.0
DECATUR COUNTY	3,952	16.6	2,909	12.2	1,670	7.0	921	3.9	318	1.3
DE KALB COUNTY	5,087	15.1	3,718	11.1	2,161	6.4	1,230	3.7	327	1.0
DELAWARE COUNTY	17,922	13.9	12,919	10.0	7,837	6.1	3,893	3.0	1,189	0.9
DUBOIS COUNTY	5,218	15.2	3,898	11.4	2,302	6.7	1,230	3.6	366	1.1
ELKHART COUNTY	18,686	13.6	13,209	9.6	7,712	5.6	4,115	3.0	1,382	1.0
FAYETTE COUNTY	4,461	15.8	3,108	11.0	1,868	6.6	936	3.3	304	1.1
FLOYD COUNTY	9,319	15.2	6,701	11.0	3,984	6.5	2,105	3.4	612	1.0
FOUNTAIN COUNTY	3,535	18.6	2,569	13.5	1,498	7.9	808	4.2	263	1.4
FRANKLIN COUNTY	2,878	14.7	2,137	10.9	1,269	6.5	685	3.5	183	0.9
FULTON COUNTY	3,883	20.1	2,783	14.4	1,666	8.6	846	4.4	271	1.4
GIBSON COUNTY	6,368	19.2	4,733	14.3	2,701	8.1	1,565	4.7	467	1.4
GRANT COUNTY	12,140	15.0	8,594	10.6	5,045	6.2	2,677	3.3	872	1.1
GREENE COUNTY	6,457	21.2	4,897	16.1	2,737	9.0	1,623	5.3	537	1.8
HAMILTON COUNTY	8,870	10.8	6,054	7.4	3,576	4.4	1,875	2.3	603	0.7
HANCOCK COUNTY	5,217	11.9	3,631	8.3	2,152	4.9	1,076	2.4	403	0.9
HARRISON COUNTY	3,895	14.3	2,751	10.1	1,656	6.1	882	3.2	213	0.8
HENDRICKS COUNTY	7,788	11.2	5,371	7.7	3,199	4.6	1,644	2.4	528	0.8
HENRY COUNTY	8,811	16.5	6,430	12.1	3,832	7.2	2,024	3.8	574	1.1
HOWARD COUNTY	11,114	12.8	7,724	8.9	4,588	5.3	2,362	2.7	774	0.9
HUNTINGTON COUNTY	6,376	17.9	4,732	13.3	2,553	7.2	1,581	4.4	598	1.7
JACKSON COUNTY	6,149	16.8	4,552	12.5	2,711	7.4	1,408	3.9	433	1.2
JASPER COUNTY	3,631	13.9	2,555	9.8	1,537	5.9	757	2.9	261	1.0

AREA NAME	POPULATION 60+ #	%	POPULATION 65+ #	%	POP 65-74 #	%	POP 75-84 #	%	POP 85+ #	%
JAY COUNTY	4,212	18.1	3,073	13.2	1,870	8.0	953	4.1	250	1.1
JEFFERSON COUNTY	4,708	15.5	3,414	11.2	2,089	6.9	1,041	3.4	284	0.9
JENNINGS COUNTY	3,147	13.8	2,240	9.8	1,384	6.1	675	3.0	181	0.8
JOHNSON COUNTY	9,132	11.8	6,708	8.7	3,638	4.7	2,120	2.7	950	1.2
KNOX COUNTY	8,495	20.3	6,359	15.2	3,812	9.1	1,989	4.8	558	1.3
KOSCIUSKO COUNTY	8,878	14.9	6,272	10.5	3,927	6.6	1,811	3.0	534	0.9
LAGRANGE COUNTY	3,454	13.5	2,414	9.4	1,532	6.0	668	2.6	214	0.8
LAKE COUNTY	69,225	13.2	45,808	8.8	29,962	5.7	12,498	2.4	3,348	0.6
LA PORTE COUNTY	16,554	15.2	11,571	10.7	7,131	6.6	3,431	3.2	1,009	0.9
LAWRENCE COUNTY	7,341	17.3	5,450	12.8	3,300	7.8	1,668	3.9	482	1.1
MADISON COUNTY	21,277	15.3	15,146	10.9	9,389	6.7	4,566	3.3	1,191	0.9
MARION COUNTY	112,012	14.6	79,298	10.4	48,[illegible]	6.3	24,337	3.2	6,707	0.9
MARSHALL COUNTY	6,631	16.9	4,880	12.5	2,735	7.0	1,634	4.2	511	1.3
MARTIN COUNTY	1,690	15.4	1,196	10.9	710	6.5	382	3.5	104	0.9
MIAMI COUNTY	5,442	13.7	3,934	9.9	2,298	5.8	1,223	3.1	413	1.0
MONROE COUNTY	9,949	10.1	7,141	7.2	4,269	4.3	2,263	2.3	609	0.6
MONTGOMERY COUNTY	6,226	17.5	4,627	13.0	2,640	7.4	1,509	4.3	478	1.3
MORGAN COUNTY	6,485	12.5	4,542	8.7	2,763	5.3	1,323	2.5	456	0.9
NEWTON COUNTY	2,425	16.3	1,751	11.8	992	6.7	568	3.8	191	1.3
NOBLE COUNTY	5,349	15.1	3,816	10.8	2,166	6.1	1,213	3.4	437	1.2
OHIO COUNTY	899	17.6	678	13.3	375	7.3	226	4.4	77	1.5
ORANGE COUNTY	3,568	19.1	2,619	14.0	1,529	8.2	855	4.6	235	1.3
OWEN COUNTY	2,873	18.1	2,173	13.7	1,300	8.2	652	4.1	221	1.4
PARKE COUNTY	3,256	19.9	2,455	15.0	1,448	8.8	776	4.7	231	1.4
PERRY COUNTY	3,466	17.9	2,557	13.2	1,484	7.7	825	4.3	248	1.3
PIKE COUNTY	2,761	20.5	2,083	15.5	1,240	9.2	657	4.9	186	1.4
PORTER COUNTY	12,200	10.2	8,213	6.9	5,244	4.4	2,298	1.9	671	0.6
POSEY COUNTY	3,864	14.6	2,820	10.7	1,673	6.3	899	3.4	248	0.9
PULASKI COUNTY	2,559	19.3	1,882	14.2	1,120	8.4	584	4.4	178	1.3
PUTNAM COUNTY	4,814	16.5	3,585	12.3	2,066	7.1	1,141	3.9	378	1.3
RANDOLPH COUNTY	4,973	16.6	3,684	12.3	2,184	7.3	1,182	3.9	318	1.1
RIPLEY COUNTY	4,277	17.5	3,185	13.1	1,828	7.5	1,049	4.3	308	1.3
RUSH COUNTY	3,472	17.7	2,555	13.0	1,444	7.4	798	4.1	313	1.6
ST. JOSEPH COUNTY	40,565	16.8	29,126	12.1	17,608	7.3	8,997	3.7	2,521	1.0
SCOTT COUNTY	3,016	14.8	2,203	10.8	1,342	6.6	624	3.1	237	1.2
SHELBY COUNTY	6,003	15.1	4,381	11.0	2,606	6.5	1,368	3.4	407	1.0
SPENCER COUNTY	3,383	17.5	2,560	13.2	1,469	7.6	822	4.2	269	1.4
STARKE COUNTY	3,859	17.5	2,860	13.0	1,770	8.0	855	3.9	235	1.1
STEUBEN COUNTY	4,223	17.1	3,007	12.2	1,879	7.6	858	3.5	270	1.1
SULLIVAN COUNTY	4,688	22.2	3,468	16.4	1,870	8.9	1,237	5.9	361	1.7
SWITZERLAND COUNTY	1,429	20.0	1,046	14.6	634	8.9	316	4.4	96	1.3
TIPPECANOE COUNTY	13,714	11.3	9,927	8.2	5,763	4.7	3,115	2.6	1,049	0.9
TIPTON COUNTY	2,783	16.5	2,025	12.0	1,201	7.1	611	3.6	213	1.3
UNION COUNTY	1,146	16.7	848	12.4	544	7.9	240	3.5	64	0.9
VANDERBURGH COUNTY	31,474	18.8	22,995	13.7	13,534	8.1	7,365	4.4	2,096	1.3
VERMILLION COUNTY	3,813	20.9	2,864	15.7	1,730	9.5	870	4.8	264	1.4
VIGO COUNTY	20,075	17.9	14,694	13.1	8,486	7.6	4,785	4.3	1,423	1.3
WABASH COUNTY	5,998	16.4	4,398	12.0	2,396	6.5	1,414	3.9	588	1.6
WARREN COUNTY	1,497	16.7	1,095	12.2	628	7.0	365	4.1	102	1.1
WARRICK COUNTY	5,014	12.1	3,578	8.6	2,126	5.1	1,076	2.6	376	0.9
WASHINGTON COUNTY	3,656	16.7	2,702	12.3	1,504	6.9	905	4.1	293	1.3
WAYNE COUNTY	13,181	17.3	9,615	12.6	5,769	7.6	2,940	3.9	906	1.2
WELLS COUNTY	3,953	15.6	2,879	11.3	1,640	6.5	946	3.7	293	1.2
WHITE COUNTY	4,491	18.8	3,259	13.7	1,963	8.2	1,005	4.2	291	1.2
WHITLEY COUNTY	4,098	15.6	3,001	11.4	1,761	6.7	952	3.6	288	1.1
IOWA	520,655	17.9	387,584	13.3	214,854	7.4	127,790	4.4	44,940	1.5
ADAIR COUNTY	2,446	25.7	1,874	19.7	1,056	11.1	570	6.0	248	2.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ADAMS COUNTY	1,411	24.6	1,077	18.8	614	10.7	338	5.9	125	2.2
ALLAMAKEE COUNTY	3,361	22.2	2,569	17.0	1,383	9.2	859	5.7	327	2.2
APPANOOSE COUNTY	3,770	24.3	2,891	18.6	1,641	10.6	954	6.2	296	1.9
AUDUBON COUNTY	2,103	24.6	1,594	18.6	849	9.9	524	6.1	221	2.6
BENTON COUNTY	4,610	19.5	3,455	14.6	1,979	8.4	1,086	4.6	390	1.6
BLACK HAWK COUNTY	19,660	14.3	14,071	10.2	8,283	6.0	4,357	3.2	1,431	1.0
BOONE COUNTY	5,591	21.4	4,306	16.4	2,209	8.4	1,510	5.8	587	2.2
BREMER COUNTY	4,307	17.4	3,261	13.1	1,839	7.4	1,057	4.3	365	1.5
BUCHANAN COUNTY	3,871	16.9	2,790	12.2	1,657	7.2	865	3.8	268	1.2
BUENA VISTA COUNTY	4,508	21.7	3,383	16.3	1,772	8.5	1,151	5.5	460	2.2
BUTLER COUNTY	3,826	21.7	2,909	16.5	1,623	9.2	978	5.5	308	1.7
CALHOUN COUNTY	3,472	25.6	2,659	19.6	1,369	10.1	960	7.1	330	2.4
CARROLL COUNTY	4,542	19.8	3,392	14.8	1,844	8.0	1,099	4.8	449	2.0
CASS COUNTY	4,081	24.1	3,185	18.8	1,717	10.1	1,073	6.3	395	2.3
CEDAR COUNTY	3,681	19.8	2,715	14.6	1,477	7.9	928	5.0	310	1.7
CERRO GORDO COUNTY	9,433	19.5	6,963	14.4	3,845	7.9	2,340	4.8	778	1.6
CHEROKEE COUNTY	3,403	21.0	2,538	15.6	1,365	8.4	840	5.2	333	2.1
CHICKASAW COUNTY	2,929	19.0	2,231	14.5	1,222	7.9	778	5.0	231	1.5
CLARKE COUNTY	1,909	22.2	1,476	17.1	838	9.7	479	5.6	159	1.8
CLAY COUNTY	3,570	18.2	2,673	13.7	1,437	7.3	913	4.7	323	1.6
CLAYTON COUNTY	4,548	21.6	3,445	16.3	1,952	9.3	1,134	5.4	359	1.7
CLINTON COUNTY	10,063	17.6	7,381	12.9	4,196	7.3	2,380	4.2	805	1.4
CRAWFORD COUNTY	3,591	19.0	2,660	14.0	1,424	7.5	920	4.9	316	1.7
DALLAS COUNTY	5,201	17.6	3,834	13.0	2,090	7.1	1,262	4.3	482	1.6
DAVIS COUNTY	2,047	22.5	1,560	17.1	874	9.6	522	5.7	164	1.8
DECATUR COUNTY	2,294	23.4	1,795	18.3	905	9.2	629	6.4	261	2.7
DELAWARE COUNTY	3,205	16.9	2,370	12.5	1,328	7.0	794	4.2	248	1.3
DES MOINES COUNTY	8,650	18.7	6,508	14.1	3,539	7.7	2,270	4.9	699	1.5
DICKINSON COUNTY	3,513	22.5	2,538	16.2	1,511	9.7	784	5.0	243	1.6
DUBUQUE COUNTY	14,027	15.0	10,402	11.1	5,827	6.2	3,396	3.6	1,179	1.3
EMMET COUNTY	2,630	19.7	1,967	14.7	1,057	7.9	653	4.9	257	1.9
FAYETTE COUNTY	5,468	21.5	4,154	16.3	2,299	9.0	1,379	5.4	476	1.9
FLOYD COUNTY	4,104	20.9	3,022	15.4	1,655	8.4	948	4.8	419	2.1
FRANKLIN COUNTY	2,934	22.5	2,246	17.2	1,272	9.8	716	5.5	258	2.0
FREMONT COUNTY	2,282	24.3	1,737	18.5	968	10.3	582	6.2	187	2.0
GREENE COUNTY	3,004	24.8	2,314	19.1	1,292	10.7	737	6.1	285	2.4
GRUNDY COUNTY	3,058	21.3	2,242	15.6	1,274	8.9	683	4.8	285	2.0
GUTHRIE COUNTY	3,120	26.0	2,374	19.8	1,226	10.2	815	6.8	333	2.8
HAMILTON COUNTY	3,717	20.8	2,744	15.4	1,532	8.6	900	5.0	312	1.7
HANCOCK COUNTY	2,807	20.3	2,131	15.4	1,170	8.5	684	4.9	277	2.0
HARDIN COUNTY	4,892	22.5	3,754	17.2	1,943	8.9	1,326	6.1	485	2.2
HARRISON COUNTY	3,638	22.3	2,816	17.2	1,485	9.1	982	6.0	349	2.1
HENRY COUNTY	3,839	20.3	2,888	15.3	1,553	8.2	952	5.0	383	2.0
HOWARD COUNTY	2,782	25.0	2,132	19.2	1,138	10.2	733	6.6	261	2.3
HUMBOLDT COUNTY	2,768	22.6	2,018	16.5	1,118	9.1	652	5.3	248	2.0
IDA COUNTY	2,104	23.6	1,621	18.2	837	9.4	546	[illegible]	238	2.7
IOWA COUNTY	3,348	21.7	2,528	16.4	1,385	9.0	825	5.3	318	2.1
JACKSON COUNTY	4,091	18.2	3,108	13.8	1,737	7.7	1,006	4.5	[illegible]	1.6
JASPER COUNTY	6,762	18.6	4,967	13.6	2,815	7.7	1,599	4.4	553	1.5
JEFFERSON COUNTY	3,208	19.7	2,451	15.0	1,334	8.2	800	4.9	317	1.9
JOHNSON COUNTY	8,017	9.8	5,811	7.1	3,281	4.0	1,879	2.3	651	0.8
JONES COUNTY	3,743	18.3	2,744	13.5	1,583	7.8	856	4.2	305	1.5
KEOKUK COUNTY	3,304	25.6	2,590	20.0	1,417	11.0	864	6.7	309	2.4
KOSSUTH COUNTY	4,422	20.2	3,296	15.1	1,817	8.3	1,164	5.3	315	1.4
LEE COUNTY	7,998	18.6	5,886	13.7	3,336	7.7	1,923	4.5	627	1.5
LINN COUNTY	23,684	14.0	17,123	10.1	9,685	5.7	5,559	3.3	1,879	1.1
LOUISA COUNTY	2,187	18.1	1,667	13.8	944	7.8	544	4.5	179	1.5

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
LUCAS COUNTY	2,490	24.1	1,898	18.4	1,051	10.2	626	6.1	221	2.1
LYON COUNTY	2,623	20.[illegible]	1,971	15.3	1,096	8.5	658	5.1	217	1.7
MADISON COUNTY	2,767	22.0	2,157	17.1	1,131	9.0	716	5.7	310	2.5
MAHASKA COUNTY	4,841	21.2	3,677	16.1	1,940	8.5	1,260	[illegible]	477	2.1
MARION COUNTY	5,642	19.0	4,270	14.4	2,357	7.9	1,400	[illegible]	513	1.7
MARSHALL COUNTY	7,766	18.6	5,770	13.9	3,179	7.6	1,848	4.[illegible]	743	1.8
MILLS COUNTY	2,366	17.6	1,709	12.7	966	7.2	550	4.2	185	1.4
MITCHELL COUNTY	2,953	23.9	2,305	18.7	1,193	9.7	800	6.5	312	2.5
MONONA COUNTY	3,047	26.1	2,354	20.1	1,309	11.2	760	6.5	285	2.4
MONROE COUNTY	2,197	23.9	1,694	18.4	903	9.8	587	6.4	204	2.2
MONTGOMERY COUNTY	3,365	25.1	2,640	19.7	1,426	10.6	[illegible]	6.5	341	2.5
MUSCATINE COUNTY	6,579	16.3	4,885	12.1	2,682	6.6	[illegible]	3.9	622	1.5
O'BRIEN COUNTY	3,868	22.8	2,985	17.6	1,568	9.[illegible]	1,031	6.1	386	2.3
OSCEOLA COUNTY	1,894	22.6	1,441	17.2	770	[illegible]	489	5.8	182	2.3
PAGE COUNTY	4,694	24.6	3,642	19.1	1,869	[illegible]	1,305	6.8	468	2.5
PALO ALTO COUNTY	2,834	22.3	2,161	17.0	1,190	[illegible].4	732	5.8	239	1.9
PLYMOUTH COUNTY	4,760	19.2	3,557	14.4	1,949	7.9	1,146	4.6	462	1.9
POCAHONTAS COUNTY	2,780	24.5	2,093	18.4	1,037	9.1	779	6.9	277	2.4
POLK COUNTY	44,025	14.[illegible]	31,495	10.4	18,395	6.1	9,897	3.3	3,203	1.1
POTTAWATTAMIE COUNTY	13,744	15.9	10,011	11.6	5,749	6.6	3,268	3.8	994	1.1
POWESHIEK COUNTY	3,824	19.8	2,868	14.9	1,519	7.9	965	5.0	384	2.0
RINGGOLD COUNTY	1,662	27.2	1,297	21.2	693	11.3	430	7.0	174	2.8
SAC COUNTY	3,472	24.6	2,664	18.9	1,415	10.0	929	6.6	320	2.3
SCOTT COUNTY	20,076	12.5	14,251	8.9	8,379	5.2	4,481	2.8	1,391	0.9
SHELBY COUNTY	3,219	21.4	2,421	16.1	1,263	8.4	801	5.3	357	2.4
SIOUX COUNTY	5,245	17.0	3,906	12.7	2,116	6.9	1,350	4.4	440	1.4
STORY COUNTY	8,134	11.2	6,036	8.3	3,239	4.5	1,999	2.8	798	1.1
TAMA COUNTY	4,379	22.4	3,326	17.0	1,806	9.2	1,124	5.8	396	2.0
TAYLOR COUNTY	2,320	27.8	1,776	21.3	938	11.2	616	7.4	222	2.7
UNION COUNTY	3,206	23.1	2,477	17.9	1,329	9.6	865	6.2	283	2.0
VAN BUREN COUNTY	2,075	24.1	1,616	18.7	893	10.4	539	6.2	184	2.1
WAPELLO COUNTY	9,006	22.4	6,819	16.9	3,938	9.[illegible]	2,173	5.4	708	1.8
WARREN COUNTY	4,326	12.4	3,224	9.2	1,723	4.9	1,041	3.0	460	1.3
WASHINGTON COUNTY	4,250	21.1	3,275	16.3	1,685	8.4	1,172	5.8	418	2.1
WAYNE COUNTY	2,425	29.6	1,880	22.9	960	11.7	693	8.5	227	2.8
WEBSTER COUNTY	8,980	19.5	6,748	14.7	3,632	7.9	2,224	4.8	892	1.9
WINNEBAGO COUNTY	3,004	23.1	2,297	17.7	1,278	9.8	766	5.9	253	1.9
WINNESHIEK COUNTY	4,084	18.7	3,093	14.1	1,622	7.4	1,144	5.2	327	1.5
WOODBURY COUNTY	18,091	17.9	13,414	13.3	7,314	7.2	4,567	4.5	1,533	1.5
WORTH COUNTY	2,187	24.1	1,693	18.7	906	10.0	581	6.4	206	2.3
WRIGHT COUNTY	3,922	24.0	2,952	18.1	1,628	10.0	959	5.9	365	2.2
KANSAS	412,296	17.4	306,263	13.0	173,411	7.3	99,397	4.2	33,455	1.4
ALLEN COUNTY	3,637	23.2	2,851	18.2	1,477	9.4	1,039	6.6	335	2.1
ANDERSON COUNTY	2,316	26.5	1,829	20.9	991	11.3	634	7.2	204	2.3
ATCHISON COUNTY	3,617	19.7	2,785	15.1	1,538	8.4	942	5.1	305	1.7
BARBER COUNTY	1,675	25.6	1,271	19.4	737	11.3	408	6.2	126	1.9
BARTON COUNTY	5,844	18.6	4,282	13.7	2,500	8.0	1,395	4.5	387	1.2
BOURBON COUNTY	4,174	26.1	3,231	20.2	1,749	11.0	1,115	7.0	367	2.3
BROWN COUNTY	3,291	27.5	2,598	21.7	1,322	11.1	933	7.8	343	2.9
BUTLER COUNTY	7,609	17.0	5,567	12.4	3,189	7.1	1,772	4.0	606	1.4
CHASE COUNTY	956	28.9	725	21.9	375	11.3	249	7.5	101	3.1
CHAUTAUQUA COUNTY	1,639	32.7	1,273	25.4	723	14.4	405	8.1	145	2.9
CHEROKEE COUNTY	5,070	22.7	3,869	17.3	2,314	10.4	1,222	5.5	333	1.5
CHEYENNE COUNTY	969	26.3	721	19.6	383	10.4	264	7.2	74	2.0
CLARK COUNTY	760	29.2	596	22.9	312	12.0	204	7.8	80	3.1
CLAY COUNTY	2,636	26.9	2,085	21.3	1,062	10.8	756	7.7	267	2.7
CLOUD COUNTY	3,497	28.0	2,810	22.5	1,425	11.4	961	7.7	424	3.4

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
COFFEY COUNTY	2,249	24.0	1,804	19.3	983	10.5	604	6.4	217	2.3
COMANCHE COUNTY	763	29.9	585	22.9	330	12.9	181	7.1	74	2.9
COWLEY COUNTY	7,831	21.3	6,012	16.3	3,315	9.0	1,999	5.4	698	1.9
CRAWFORD COUNTY	9,442	24.9	7,340	19.4	4,131	10.9	2,408	6.4	801	2.1
DECATUR COUNTY	1,241	27.5	977	21.7	465	10.3	376	8.3	136	3.0
DICKINSON COUNTY	4,984	24.7	3,940	19.5	2,009	10.0	1,354	6.7	577	2.9
DONIPHAN COUNTY	2,007	21.7	1,561	16.8	871	9.4	509	5.5	181	2.0
DOUGLAS COUNTY	6,908	10.2	5,056	7.5	2,744	4.1	1,693	2.5	619	0.9
EDWARDS COUNTY	1,169	27.4	883	20.7	490	11.5	288	6.7	105	2.5
ELK COUNTY	1,282	32.7	1,034	26.4	562	14.3	353	9.0	119	3.0
ELLIS COUNTY	3,619	13.9	2,647	10.1	1,611	6.2	809	3.1	227	0.9
ELLSWORTH COUNTY	1,915	28.8	1,516	22.8	853	12.8	507	7.6	156	2.3
FINNEY COUNTY	2,776	11.7	1,951	8.2	1,185	5.0	559	2.3	207	0.9
FORD COUNTY	4,030	16.6	2,992	12.3	1,693	7.0	953	3.9	346	1.4
FRANKLIN COUNTY	4,707	21.3	3,667	16.6	1,979	9.0	1,267	5.7	421	1.9
GEARY COUNTY	2,910	9.7	2,029	6.8	1,202	4.0	602	2.0	225	0.8
GOVE COUNTY	776	20.8	617	16.6	379	10.2	189	5.1	49	1.3
GRAHAM COUNTY	909	22.8	710	17.8	393	9.8	253	6.3	64	1.6
GRANT COUNTY	748	10.7	516	7.4	346	5.0	130	1.9	40	0.6
GRAY COUNTY	853	16.6	640	12.5	368	7.2	194	3.8	78	1.5
GREELEY COUNTY	345	18.7	249	13.5	147	8.0	82	4.4	20	1.1
GREENWOOD COUNTY	2,649	30.2	2,106	24.0	1,120	12.8	747	8.5	239	2.7
HAMILTON COUNTY	589	23.4	458	18.2	266	10.6	146	5.8	46	1.8
HARPER COUNTY	2,262	29.1	1,769	22.7	925	11.9	643	8.3	201	2.6
HARVEY COUNTY	6,036	19.8	4,685	15.3	2,314	7.6	1,709	5.6	662	2.2
HASKELL COUNTY	485	12.7	343	9.0	208	5.5	106	2.8	29	0.8
HODGEMAN COUNTY	537	23.7	399	17.6	223	9.8	130	5.7	46	2.0
JACKSON COUNTY	2,335	20.1	1,820	15.6	1,024	8.8	581	5.0	215	1.8
JEFFERSON COUNTY	2,892	19.0	2,177	14.3	1,182	7.8	696	4.6	299	2.0
JEWELL COUNTY	1,506	28.7	1,179	22.5	640	12.2	398	7.6	141	2.7
JOHNSON COUNTY	30,941	11.4	20,644	7.6	13,006	4.8	5,862	2.2	1,776	0.7
KEARNY COUNTY	488	14.2	336	9.8	216	6.3	102	3.0	18	0.5
KINGMAN COUNTY	2,111	23.6	1,581	17.6	873	9.7	510	5.7	198	2.2
KIOWA COUNTY	965	23.9	742	18.3	432	10.7	227	5.6	83	2.1
LABETTE COUNTY	5,735	22.3	4,361	17.0	2,425	9.4	1,440	5.6	496	1.9
LANE COUNTY	550	22.2	420	17.0	247	10.0	140	5.7	33	1.3
LEAVENWORTH COUNTY	7,343	13.4	5,280	9.6	3,186	5.8	1,628	3.0	466	0.9
LINCOLN COUNTY	1,312	31.7	1,054	25.4	508	12.3	395	9.5	151	3.6
LINN COUNTY	2,255	27.4	1,752	21.3	974	11.8	601	7.3	177	2.1
LOGAN COUNTY	739	21.2	578	16.6	300	8.6	210	6.0	68	2.0
LYON COUNTY	5,417	15.4	4,152	11.8	2,209	6.3	1,435	4.1	508	1.4
MCPHERSON COUNTY	5,686	21.2	4,378	16.3	2,307	8.6	1,495	5.6	576	2.1
MARION COUNTY	3,858	28.5	3,039	22.5	1,595	11.8	1,052	7.8	392	2.9
MARSHALL COUNTY	3,547	27.7	2,573	20.1	1,478	11.6	818	6.4	277	2.2
MEADE COUNTY	1,078	22.5	846	17.7	466	9.7	294	6.1	86	1.8
MIAMI COUNTY	4,306	19.9	3,295	15.2	1,847	8.5	1,104	5.1	344	1.6
MITCHELL COUNTY	2,072	25.5	1,667	20.5	927	11.4	529	6.5	211	2.6
MONTGOMERY COUNTY	9,711	23.0	7,456	17.6	4,149	9.8	2,529	6.0	779	1.8
MORRIS COUNTY	1,865	29.1	1,457	22.7	792	12.3	466	7.3	199	3.1
MORTON COUNTY	491	14.2	324	9.4	195	5.6	106	3.1	23	0.7
NEMAHA COUNTY	2,790	24.9	2,182	19.5	1,121	10.0	774	6.9	287	2.6
NEOSHO COUNTY	4,297	22.7	3,328	17.5	1,820	9.6	1,131	6.0	377	2.0
NESS COUNTY	1,180	26.2	917	20.4	521	11.6	301	6.7	95	2.1
NORTON COUNTY	1,789	26.7	1,429	21.4	760	11.4	503	7.5	166	2.5
OSAGE COUNTY	3,313	21.6	2,541	16.6	1,371	8.9	854	5.6	316	2.1
OSBORNE COUNTY	1,851	31.1	1,472	24.7	737	12.4	520	8.7	215	3.6
OTTAWA COUNTY	1,601	26.8	1,276	21.4	692	11.6	421	7.1	163	2.7

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
PAWNEE COUNTY	1,883	23.3	1,357	16.8	814	10.1	407	5.0	136	1.7
PHILLIPS COUNTY	1,982	26.8	1,532	20.7	772	10.4	533	7.2	228	3.1
POTTAWATOMIE COUNTY	2,855	19.3	2,201	14.9	1,191	8.1	766	5.2	244	1.7
PRATT COUNTY	2,387	23.2	1,840	17.9	982	9.6	628	6.1	230	2.2
RAWLINS COUNTY	1,014	24.7	777	18.9	429	10.5	271	6.6	77	1.9
RENO COUNTY	11,956	18.4	8,922	13.7	5,132	7.9	2,831	4.4	959	1.5
REPUBLIC COUNTY	2,367	31.3	1,871	24.7	954	12.6	658	8.7	259	3.4
RICE COUNTY	2,943	24.7	2,267	19.1	1,287	10.8	691	5.8	289	2.4
RILEY COUNTY	4,775	7.5	3,487	5.5	1,965	3.1	1,102	1.7	420	0.7
ROOKS COUNTY	1,768	25.2	1,387	19.8	798	11.4	440	6.3	149	2.1
RUSH COUNTY	1,306	28.9	1,001	22.2	564	12.5	333	7.4	104	2.3
RUSSELL COUNTY	2,288	25.8	1,742	19.6	1,049	11.8	534	6.0	159	1.8
SALINE COUNTY	8,039	16.4	5,949	12.2	3,430	7.0	1,933	4.0	586	1.2
SCOTT COUNTY	1,036	17.9	745	12.9	456	7.9	194	3.4	95	1.6
SEDGWICK COUNTY	50,531	13.8	35,119	9.6	21,217	5.8	10,575	2.9	3,327	0.9
SEWARD COUNTY	2,102	12.3	1,475	8.6	912	5.3	440	2.6	123	0.7
SHAWNEE COUNTY	24,930	16.1	18,529	12.0	10,322	6.7	6,132	4.0	2,075	1.3
SHERIDAN COUNTY	721	20.3	561	15.8	263	7.4	227	6.4	71	2.0
SHERMAN COUNTY	1,403	18.1	1,030	13.3	566	7.3	346	4.5	118	1.5
SMITH COUNTY	1,810	30.4	1,442	24.2	697	11.7	530	8.9	215	3.6
STAFFORD COUNTY	1,764	31.0	1,369	24.0	745	13.1	462	8.1	162	2.8
STANTON COUNTY	300	12.8	217	9.3	119	5.1	74	3.2	24	1.0
STEVENS COUNTY	829	17.5	577	12.2	366	7.7	156	3.3	55	1.2
SUMNER COUNTY	5,589	22.4	4,220	16.9	2,322	9.3	1,368	5.5	530	2.1
THOMAS COUNTY	1,374	16.3	1,044	12.4	577	6.8	365	4.3	102	1.2
TREGO COUNTY	1,063	25.5	811	19.5	474	11.4	269	6.5	68	1.6
WABAUNSEE COUNTY	1,646	24.0	1,273	18.5	641	9.3	465	6.8	167	2.4
WALLACE COUNTY	407	19.9	290	14.2	150	7.3	114	5.6	26	1.3
WASHINGTON COUNTY	2,569	30.1	2,048	24.0	1,126	13.2	691	8.1	231	2.7
WICHITA COUNTY	468	15.4	345	11.3	212	7.0	108	3.6	25	0.8
WILSON COUNTY	3,154	26.0	2,443	20.1	1,378	11.4	811	6.7	254	2.1
WOODSON COUNTY	1,390	30.2	1,062	23.1	567	12.3	365	7.9	130	2.8
WYANDOTTE COUNTY	27,911	16.2	20,095	11.7	11,726	6.8	6,367	3.7	2,002	1.2
KENTUCKY	563,601	15.4	409,828	11.2	248,988	6.8	125,804	3.4	35,036	1.0
ADAIR COUNTY	3,167	20.8	2,308	15.2	1,440	9.5	701	4.6	167	1.1
ALLEN COUNTY	2,912	20.6	2,165	15.3	1,339	9.5	678	4.8	148	1.0
ANDERSON COUNTY	2,057	16.4	1,522	12.1	961	7.6	431	3.4	130	1.0
BALLARD COUNTY	1,979	22.5	1,519	17.3	873	9.9	487	5.5	159	1.8
BARREN COUNTY	6,460	19.0	4,792	14.1	2,902	8.5	1,457	4.3	433	1.3
BATH COUNTY	1,870	18.7	1,400	14.0	831	8.3	431	4.3	138	1.4
BELL COUNTY	5,477	16.0	4,015	11.7	2,476	7.2	1,232	3.6	307	0.9
BOONE COUNTY	4,549	9.9	3,125	6.8	1,988	4.3	926	2.0	211	0.5
BOURBON COUNTY	3,415	17.6	2,469	12.7	1,474	7.6	769	4.0	226	1.2
BOYD COUNTY	9,189	16.6	6,619	11.9	4,113	7.4	1,972	3.6	534	1.0
BOYLE COUNTY	4,220	16.8	3,003	12.0	1,793	7.2	891	3.6	319	1.3
BRACKEN COUNTY	1,566	20.2	1,175	15.2	705	9.1	362	4.7	108	1.4
BREATHITT COUNTY	2,345	13.8	1,725	10.1	1,117	6.6	465	2.7	143	0.8
BRECKINRIDGE COUNTY	3,157	18.7	2,344	13.9	1,439	8.5	726	4.3	179	1.1
BULLITT COUNTY	3,378	7.8	2,261	5.2	1,411	3.3	693	1.6	157	0.4
BUTLER COUNTY	2,100	19.0	1,600	14.5	931	8.4	519	4.7	150	1.4
CALDWELL COUNTY	3,153	23.4	2,413	17.9	1,428	10.6	743	5.5	242	1.8
CALLOWAY COUNTY	5,745	19.1	4,354	14.5	2,611	8.7	1,395	4.6	348	1.2
CAMPBELL COUNTY	13,962	16.8	10,123	12.1	6,005	7.2	3,200	3.8	918	1.1
CARLISLE COUNTY	1,270	23.1	980	17.9	601	11.0	284	5.2	95	1.7
CARROLL COUNTY	1,676	18.1	1,211	13.1	760	8.2	357	3.9	94	1.0
CARTER COUNTY	3,772	15.1	2,757	11.0	1,768	7.1	848	3.4	141	0.6
CASEY COUNTY	2,744	18.5	1,981	13.4	1,248	8.4	583	3.9	150	1.0

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
CHRISTIAN COUNTY	7,998	12.0	5,910	8.8	3,481	5.2	1,854	2.8	575	0.9
CLARK COUNTY	4,045	14.3	2,954	10.4	1,7[illegible]	6.2	936	3.3	260	0.9
CLAY COUNTY	2,944	12.9	2,188	9.6	1,405	6.2	608	2.7	175	0.8
CLINTON COUNTY	1,799	19.3	1,314	14.1	826	8.9	398	4.3	90	1.0
CRITTENDEN COUNTY	2,083	22.6	1,565	17.0	941	10.2	480	5.2	144	1.6
CUMBERLAND COUNTY	1,567	21.5	1,156	15.9	707	9.7	360	4.9	89	1.2
DAVIESS COUNTY	12,880	15.0	9,354	10.9	5,686	6.6	2,843	3.3	825	1.0
EDMONSON COUNTY	1,665	16.7	1,221	12.3	798	8.0	342	3.4	81	0.8
ELLIOTT COUNTY	1,065	15.4	761	11.0	512	7.4	210	3.0	39	0.6
ESTILL COUNTY	2,514	17.3	1,957	13.5	1,100	7.6	682	4.6	195	1.3
FAYETTE COUNTY	24,764	12.1	17,546	8.6	10,665	5.2	5,286	2.6	1,595	0.8
FLEMING COUNTY	2,381	19.3	1,762	14.3	998	8.1	588	4.8	176	1.4
FLOYD COUNTY	6,855	14.1	4,852	9.9	3,134	6.4	1,363	2.8	355	0.7
FRANKLIN COUNTY	6,003	14.4	4,235	10.1	2,690	6.4	1,199	2.9	346	0.8
FULTON COUNTY	2,192	24.4	1,711	19.1	981	10.9	565	6.3	165	1.8
GALLATIN COUNTY	742	15.3	543	11.2	351	7.2	160	3.3	32	0.7
GARRARD COUNTY	2,036	18.8	1,527	14.1	927	8.5	449	4.1	151	1.4
GRANT COUNTY	2,167	16.3	1,604	12.1	958	7.2	499	3.7	147	1.1
GRAVES COUNTY	7,868	23.1	5,954	17.5	3,431	10.1	1,996	5.9	527	1.5
GRAYSON COUNTY	3,894	18.7	2,855	13.7	1,765	8.5	863	4.1	227	1.1
GREEN COUNTY	2,317	21.0	1,713	15.5	1,052	9.5	497	4.5	164	1.5
GREENUP COUNTY	4,974	12.7	3,488	8.9	2,156	5.5	1,051	2.7	281	0.7
HANCOCK COUNTY	1,040	13.4	789	10.2	485	6.3	230	3.0	74	1.0
HARDIN COUNTY	7,267	8.2	5,111	5.7	3,222	3.6	1,493	1.7	396	0.4
HARLAN COUNTY	6,344	15.1	4,578	10.9	2,882	6.9	1,361	3.2	335	0.8
HARRISON COUNTY	3,144	20.7	2,372	15.6	1,395	9.2	730	4.8	247	1.6
HART COUNTY	2,852	18.5	2,028	13.2	1,290	8.4	582	3.8	156	1.0
HENDERSON COUNTY	6,366	15.6	4,645	11.4	2,751	6.7	1,478	3.6	416	1.0
HENRY COUNTY	2,381	18.7	1,732	13.6	1,026	8.1	567	4.5	139	1.1
HICKMAN COUNTY	1,458	24.0	1,133	18.7	660	10.9	361	6.0	112	1.8
HOPKINS COUNTY	8,288	17.9	6,128	13.3	3,541	7.7	1,931	4.2	656	1.4
JACKSON COUNTY	1,982	1[illegible].5	1,483	12.4	888	7.4	475	4.0	120	1.0
JEFFERSON COUNTY	105,538	15.4	75,503	11.0	45,868	6.7	23,192	3.4	6,443	0.9
JESSAMINE COUNTY	2,864	11.0	2,056	7.9	1,230	4.7	632	2.4	194	0.7
JOHNSON COUNTY	3,812	15.6	2,779	11.4	1,744	7.1	817	3.3	218	0.9
KENTON COUNTY	21,003	15.3	15,305	11.2	9,148	6.7	4,879	3.6	1,278	0.9
KNOTT COUNTY	2,375	13.2	1,696	9.5	1,067	5.9	501	2.8	128	0.7
KNOX COUNTY	4,864	16.1	3,573	11.8	2,176	7.2	1,144	3.8	253	0.8
LARUE COUNTY	2,349	19.7	1,735	14.6	1,064	8.9	532	4.5	139	1.2
LAUREL COUNTY	5,815	14.9	4,219	10.8	2,545	6.5	1,314	3.4	360	0.9
LAWRENCE COUNTY	2,426	17.2	1,830	13.0	1,097	7.8	557	3.9	176	1.2
LEE COUNTY	1,508	19.4	1,192	15.4	641	8.3	423	5.5	128	1.7
LESLIE COUNTY	1,578	10.6	1,140	7.7	744	5.0	315	2.1	81	0.5
LETCHER COUNTY	4,317	14.1	3,146	10.3	1,977	6.4	945	3.1	224	0.7
LEWIS COUNTY	2,177	15.0	1,601	11.0	1,029	7.1	446	3.1	126	0.9
LINCOLN COUNTY	3,400	17.8	2,489	13.1	1,462	7.7	814	4.3	213	1.1
LIVINGSTON COUNTY	1,810	19.6	1,314	14.3	842	9.1	356	3.9	116	1.3
LOGAN COUNTY	4,723	19.6	3,489	14.5	2,115	8.8	1,062	4.4	312	1.3
LYON COUNTY	1,426	22.0	1,044	16.1	693	10.7	279	4.3	72	1.1
MCCRACKEN COUNTY	11,796	19.2	8,752	14.3	5,262	8.6	2,691	4.4	799	1.3
MCCREARY COUNTY	2,246	14.4	1,614	10.3	1,028	6.6	492	3.1	94	0.6
MCLEAN COUNTY	1,905	18.9	1,427	14.1	844	8.4	484	4.8	99	1.0
MADISON COUNTY	6,570	12.3	4,820	9.0	2,806	5.3	1,548	2.9	466	0.9
MAGOFFIN COUNTY	1,667	12.3	1,184	8.8	715	5.3	361	2.7	108	0.8
MARION COUNTY	2,798	15.6	2,104	11.7	1,308	7.3	632	3.5	164	0.9
MARSHALL COUNTY	5,169	20.2	3,793	14.8	2,378	9.3	1,088	4.2	327	1.3
MARTIN COUNTY	1,473	10.6	1,049	7.5	647	4.6	321	2.3	81	0.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
MASON COUNTY	3,350	18.9	2,414	13.6	1,435	8.1	756	4.3	223	1.3
MEADE COUNTY	1,893	8.3	1,322	5.8	853	3.7	347	1.5	122	0.5
MENIFEE COUNTY	786	15.4	570	11.1	361	7.1	165	3.2	44	0.9
MERCER COUNTY	3,449	18.1	2,492	13.1	1,497	7.9	792	4.2	203	1.1
METCALFE COUNTY	1,850	19.5	1,373	14.5	839	8.8	441	4.6	93	1.0
MONROE COUNTY	2,478	20.1	1,847	15.0	1,156	9.4	539	4.4	152	1.2
MONTGOMERY COUNTY	2,910	14.5	2,117	10.6	1,272	6.3	644	3.2	201	1.0
MORGAN COUNTY	1,976	16.3	1,458	12.0	882	7.3	436	3.6	140	1.2
MUHLENBERG COUNTY	5,876	18.2	4,361	13.5	2,650	8.2	1,330	4.1	381	1.2
NELSON COUNTY	3,929	14.2	2,824	10.2	1,617	5.9	944	3.4	263	1.0
NICHOLAS COUNTY	1,417	19.8	1,050	14.7	648	9.1	318	4.4	84	1.2
OHIO COUNTY	4,041	18.6	3,016	13.9	1,775	8.2	964	4.4	277	1.3
OLDHAM COUNTY	2,369	8.5	1,601	5.8	1,043	3.8	443	1.6	115	0.4
OWEN COUNTY	1,843	20.7	1,379	15.5	838	9.4	414	4.6	127	1.4
OWSLEY COUNTY	1,038	18.2	790	13.8	464	8.1	278	4.9	48	0.8
PENDLETON COUNTY	1,836	16.7	1,365	12.4	785	7.1	441	4.0	139	1.3
PERRY COUNTY	4,458	13.2	3,222	9.5	1,955	5.8	1,006	3.0	261	0.8
PIKE COUNTY	9,683	11.9	6,738	8.3	4,292	5.3	1,930	2.4	516	0.6
POWELL COUNTY	1,520	13.7	1,115	10.0	672	6.1	344	3.1	99	0.9
PULASKI COUNTY	7,920	17.3	5,792	12.6	3,502	7.6	1,786	3.9	504	1.1
ROBERTSON COUNTY	490	21.6	370	16.3	227	10.0	114	5.0	29	1.3
ROCKCASTLE COUNTY	2,436	17.4	1,795	12.8	1,104	7.9	561	4.0	130	0.9
ROWAN COUNTY	2,435	12.8	1,779	9.3	1,068	5.6	570	3.0	141	0.7
RUSSELL COUNTY	2,788	20.3	2,016	14.7	1,260	9.2	610	4.4	146	1.1
SCOTT COUNTY	3,161	14.5	2,315	10.6	1,346	6.2	711	3.3	259	1.2
SHELBY COUNTY	3,926	16.8	2,909	12.5	1,693	7.3	920	3.9	296	1.3
SIMPSON COUNTY	2,649	18.1	1,941	13.2	1,173	8.0	592	4.0	176	1.2
SPENCER COUNTY	921	15.5	663	11.2	407	6.9	208	3.5	48	0.8
TAYLOR COUNTY	3,546	16.7	2,596	12.3	1,576	7.4	828	3.9	192	0.9
TODD COUNTY	2,475	20.8	1,851	15.6	1,080	9.1	630	5.3	141	1.2
TRIGG COUNTY	2,036	21.7	1,483	15.8	942	10.0	418	4.5	123	1.3
TRIMBLE COUNTY	1,013	16.2	733	11.7	439	7.0	222	3.6	72	1.2
UNION COUNTY	2,581	14.5	1,899	10.7	1,114	6.3	618	3.5	167	0.9
WARREN COUNTY	9,741	13.6	7,059	9.8	4,328	6.0	2,085	2.9	646	0.9
WASHINGTON COUNTY	1,986	18.5	1,454	13.5	881	8.2	453	4.2	120	1.1
WAYNE COUNTY	2,944	17.3	2,148	12.6	1,346	7.9	643	3.8	159	0.9
WEBSTER COUNTY	3,134	21.1	2,414	16.3	1,327	8.9	831	5.6	256	1.7
WHITLEY COUNTY	5,513	16.5	4,102	12.3	2,487	7.4	1,305	3.9	310	0.9
WOLFE COUNTY	1,147	17.1	827	12.3	491	7.3	259	3.9	77	1.1
WOODFORD COUNTY	2,408	13.5	1,743	9.8	1,057	5.9	516	2.9	170	1.0
LOUISIANA	566,011	13.5	404,279	9.6	254,901	6.1	118,843	2.8	30,535	0.7
ACADIA PARISH	8,490	15.0	6,118	10.8	3,893	6.9	1,797	3.2	428	0.8
ALLEN PARISH	3,668	17.1	2,678	12.5	1,631	7.6	812	3.8	235	1.1
ASCENSION PARISH	5,272	10.5	3,694	7.4	2,326	4.6	1,103	2.2	265	0.5
ASSUMPTION PARISH	2,754	12.5	1,983	9.0	1,270	5.8	582	2.6	131	0.6
AVOYELLES PARISH	7,728	18.7	5,642	13.6	3,473	8.4	1,751	4.2	418	1.0
BEAUREGARD PARISH	4,025	13.6	2,927	9.9	1,888	6.4	801	2.7	238	0.8
BIENVILLE PARISH	3,718	22.7	2,828	17.3	1,761	10.7	836	5.1	231	1.4
BOSSIER PARISH	7,981	9.9	5,509	6.8	3,387	4.2	1,646	2.0	476	0.6
CADDO PARISH	40,079	15.9	29,205	11.6	17,623	7.0	9,062	3.6	2,520	1.0
CALCASIEU PARISH	20,975	12.5	14,485	8.7	9,630	5.8	3,892	2.3	963	0.6
CALDWELL PARISH	2,184	20.3	1,663	15.5	1,047	9.7	507	4.7	109	1.0
CAMERON PARISH	1,190	12.7	851	9.1	554	5.9	239	2.6	58	0.6
CATAHOULA PARISH	2,123	17.3	1,547	12.6	962	7.8	471	3.8	114	0.9
CLAIBORNE PARISH	4,090	23.9	3,164	18.5	1,802	10.5	1,052	6.2	310	1.8
CONCORDIA PARISH	3,349	14.6	2,355	10.2	1,512	6.6	676	2.9	167	0.7
DE SOTO PARISH	5,141	20.0	3,923	15.2	2,320	9.0	1,185	4.6	418	1.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
EAST BATON ROUGE PARISH	37,252	10.2	25,382	6.9	16,480	4.5	6,998	1.9	1,904	0.5
EAST CARROLL PARISH	1,988	16.9	1,513	12.9	891	7.6	464	3.9	158	1.3
EAST FELICIANA PARISH	2,949	15.5	2,238	11.8	1,248	6.6	752	4.0	238	1.3
EVANGELINE PARISH	5,575	16.7	3,948	11.8	2,598	7.8	1,116	3.3	234	0.7
FRANKLIN PARISH	4,810	19.9	3,665	15.2	2,300	9.5	1,092	4.5	273	1.1
GRANT PARISH	3,285	19.7	2,428	14.5	1,494	8.9	731	4.4	203	1.2
IBERIA PARISH	8,091	12.7	5,591	8.8	3,694	5.8	1,497	2.3	400	0.6
IBERVILLE PARISH	4,527	14.1	3,285	10.2	2,072	6.4	971	3.0	252	0.8
JACKSON PARISH	3,714	21.4	2,789	16.1	1,768	10.2	764	4.4	257	1.5
JEFFERSON PARISH	47,499	10.4	31,882	7.0	21,204	4.7	8,786	1.9	1,892	0.4
JEFFERSON DAVIS PARISH	4,905	15.2	3,525	11.0	2,293	7.1	978	3.0	254	0.8
LAFAYETTE PARISH	14,494	9.7	10,060	6.7	6,506	4.3	2,850	1.9	713	0.5
LAFOURCHE PARISH	8,723	10.6	5,929	7.2	3,884	4.7	1,626	2.0	419	0.5
LA SALLE PARISH	3,279	19.3	2,402	14.1	1,419	8.3	765	4.5	218	1.3
LINCOLN PARISH	5,655	14.2	4,262	10.7	2,519	6.3	1,316	3.3	427	1.1
LIVINGSTON PARISH	5,808	9.9	4,043	6.9	2,673	4.5	1,114	1.9	256	0.4
MADISON PARISH	2,963	18.5	2,303	14.4	1,281	8.0	786	4.9	236	1.5
MOREHOUSE PARISH	6,241	17.9	4,593	13.2	2,832	8.1	1,393	4.0	368	1.1
NATCHITOCHES PARISH	6,833	17.1	5,112	12.8	3,168	7.9	1,495	3.8	449	1.1
ORLEANS PARISH	88,710	15.9	65,323	11.7	39,601	7.1	20,693	3.7	5,029	0.9
OUACHITA PARISH	19,284	13.8	13,924	10.0	8,661	6.2	4,162	3.0	1,101	0.8
PLAQUEMINES PARISH	2,442	9.4	1,672	6.4	1,157	4.4	442	1.7	73	0.3
POINTE COUPEE PARISH	3,783	15.7	2,736	11.4	1,740	7.2	814	3.4	182	0.8
RAPIDES PARISH	20,045	14.8	14,309	10.6	9,010	6.7	4,177	3.1	1,122	0.8
RED RIVER PARISH	2,049	19.6	1,540	14.8	939	9.0	484	4.6	117	1.1
RICHLAND PARISH	4,463	20.1	3,328	15.0	1,979	8.9	1,045	4.7	304	1.4
SABINE PARISH	5,290	20.9	3,823	15.1	2,406	9.5	1,098	4.3	319	1.3
ST. BERNARD PARISH	7,005	10.9	4,615	7.2	3,139	4.9	1,246	1.9	230	0.4
ST. CHARLES PARISH	3,423	9.2	2,377	6.4	1,492	4.0	721	1.9	164	0.4
ST. HELENA PARISH	1,594	16.2	1,187	12.1	822	8.4	296	3.0	69	0.7
ST. JAMES PARISH	2,644	12.3	1,920	8.9	1,179	5.5	599	2.8	142	0.7
ST. JOHN THE BAPTIST PARISH	2,997	9.4	2,133	6.7	1,335	4.2	651	2.0	147	0.5
ST. LANDRY PARISH	12,669	15.1	9,023	10.7	5,900	7.0	2,508	3.0	615	0.7
ST. MARTIN PARISH	4,852	12.1	3,357	8.3	2,191	5.4	928	2.3	238	0.6
ST. MARY PARISH	6,753	10.5	4,677	7.3	3,023	4.7	1,320	2.1	334	0.5
ST. TAMMANY PARISH	12,077	10.9	8,289	7.5	5,371	4.8	2,301	2.1	617	0.6
TANGIPAHOA PARISH	11,476	14.2	8,282	10.3	5,339	6.6	2,359	2.9	584	0.7
TENSAS PARISH	1,819	21.3	1,370	16.1	859	10.1	408	4.8	103	1.2
TERREBONNE PARISH	8,646	9.2	5,890	6.2	3,901	4.1	1,615	1.7	374	0.4
UNION PARISH	4,443	21.0	3,373	15.9	2,039	9.6	997	4.7	337	1.6
VERMILION PARISH	7,766	16.0	5,543	11.4	3,496	7.2	1,688	3.5	359	0.7
VERNON PARISH	4,632	8.7	3,285	6.1	2,135	4.0	901	1.7	249	0.5
WASHINGTON PARISH	7,598	17.2	5,508	12.5	3,491	7.9	1,626	3.7	391	0.9
WEBSTER PARISH	8,741	20.0	6,380	14.6	3,875	8.9	1,936	4.4	569	1.3
WEST BATON ROUGE PARISH	2,201	11.5	1,507	7.9	985	5.2	402	2.1	120	0.6
WEST CARROLL PARISH	2,638	20.4	1,956	15.1	1,288	10.0	532	4.1	136	1.1
WEST FELICIANA PARISH	1,150	9.4	857	7.0	560	4.6	230	1.9	67	0.5
WINN PARISH	3,463	20.1	2,554	14.8	1,585	9.2	758	4.4	211	1.2
MAINE	191,729	17.0	140,918	12.5	82,288	7.3	44,531	4.0	14,099	1.3
ANDROSCOGGIN COUNTY	17,268	17.3	12,758	12.8	7,223	7.2	4,251	4.3	1,284	1.3
AROOSTOOK COUNTY	13,285	14.5	9,534	10.4	5,808	6.4	2,876	3.1	850	0.9
CUMBERLAND COUNTY	37,447	17.4	27,498	12.7	15,926	7.4	8,720	4.0	2,852	1.3
FRANKLIN COUNTY	4,387	16.2	3,221	11.9	1,882	6.9	1,038	3.8	301	1.1
HANCOCK COUNTY	8,577	20.5	6,429	15.4	3,691	8.8	2,041	4.9	697	1.7
KENNEBEC COUNTY	18,285	16.6	13,411	12.2	7,787	7.1	4,301	3.9	1,323	1.2
KNOX COUNTY	7,031	21.3	5,280	16.0	2,878	8.7	1,774	5.4	628	1.9
LINCOLN COUNTY	5,411	21.1	4,056	15.8	2,386	9.3	1,260	4.9	410	1.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
OXFORD COUNTY	9,316	19.0	6,867	14.0	3,973	8.1	2,101	4.3	793	1.6
PENOBSCOT COUNTY	19,472	14.2	14,158	10.3	8,418	6.1	4,396	3.2	1,344	1.0
PISCATAQUIS COUNTY	3,423	19.4	2,532	14.4	1,500	8.5	774	4.4	258	1.5
SAGADAHOC COUNTY	4,473	15.5	3,288	11.4	1,926	6.7	1,040	3.6	322	1.1
SOMERSET COUNTY	7,726	17.2	5,678	12.6	3,303	7.3	1,771	3.9	604	1.3
WALDO COUNTY	4,590	16.2	3,362	11.8	2,119	7.5	967	3.4	276	1.0
WASHINGTON COUNTY	6,810	19.5	5,076	14.5	2,903	8.3	1,630	4.7	543	1.6
YORK COUNTY	24,228	17.3	17,770	12.7	10,565	7.6	5,591	4.0	1,614	1.2
MARYLAND	575,989	13.7	395,609	9.4	247,209	5.9	115,735	2.7	32,665	0.8
ALLEGANY COUNTY	17,078	21.2	12,389	15.4	7,571	9.4	3,833	4.8	985	1.2
ANNE ARUNDEL COUNTY	38,537	10.4	25,085	6.8	16,566	4.5	6,761	1.8	1,758	0.5
BALTIMORE COUNTY	103,326	15.8	69,364	10.6	43,641	6.7	19,938	3.0	5,785	0.9
CALVERT COUNTY	4,254	12.3	2,871	8.3	1,915	5.5	753	2.2	203	0.6
CAROLINE COUNTY	4,399	19.0	3,170	13.7	1,941	8.4	975	4.2	254	1.1
CARROLL COUNTY	12,615	13.1	8,991	9.3	5,440	5.6	2,804	2.9	747	0.8
CECIL COUNTY	8,085	13.4	5,553	9.2	3,485	5.8	1,610	2.7	458	0.8
CHARLES COUNTY	6,073	8.3	4,005	5.5	2,674	3.7	1,059	1.5	272	0.4
DORCHESTER COUNTY	6,543	21.4	4,766	15.6	2,834	9.3	1,490	4.9	442	1.4
FREDERICK COUNTY	14,428	12.6	10,221	8.9	6,291	5.5	3,034	2.6	896	0.8
GARRETT COUNTY	4,344	16.4	3,160	11.9	1,885	7.1	949	3.6	326	1.2
HARFORD COUNTY	14,210	9.7	9,371	6.4	5,924	4.1	2,674	1.8	773	0.5
HOWARD COUNTY	9,435	8.0	6,081	5.1	3,957	3.3	1,714	1.4	410	0.3
KENT COUNTY	3,458	20.7	2,527	15.1	1,520	9.1	783	4.7	224	1.3
MONTGOMERY COUNTY	75,837	13.1	50,905	8.8	31,462	5.4	14,729	2.5	4,714	0.8
PRINCE GEORGE'S COUNTY	56,990	8.6	36,508	5.5	23,696	3.6	10,001	1.5	2,811	0.4
QUEEN ANNE'S COUNTY	4,461	17.5	3,083	12.1	1,946	7.6	860	3.4	277	1.1
ST. MARY'S COUNTY	5,900	9.9	4,015	6.7	2,561	4.3	1,153	1.9	301	0.5
SOMERSET COUNTY	4,056	21.1	2,987	15.6	1,846	9.6	889	4.6	252	1.3
TALBOT COUNTY	6,137	24.0	4,469	17.5	2,752	10.7	1,310	5.1	407	1.6
WASHINGTON COUNTY	18,816	16.6	13,501	11.9	8,177	7.2	4,073	3.6	1,251	1.1
WICOMICO COUNTY	10,807	16.7	7,755	12.0	4,584	7.1	2,401	3.7	770	1.2
WORCESTER COUNTY	6,043	19.6	4,257	13.8	2,702	8.7	1,188	3.8	367	1.2
BALTIMORE CITY	140,157	17.8	100,575	12.8	61,839	7.9	30,754	3.9	7,982	1.0
MASSACHUSETTS	1,003,915	17.5	726,531	12.7	422,615	7.4	230,008	4.0	73,908	1.3
BARNSTABLE COUNTY	40,541	27.4	30,725	20.8	19,046	12.9	9,254	6.3	2,425	1.6
BERKSHIRE COUNTY	28,924	19.9	20,931	14.4	12,200	8.4	6,514	4.5	2,217	1.5
BRISTOL COUNTY	86,738	18.3	62,060	13.1	36,983	7.8	19,460	4.1	5,617	1.2
DUKES COUNTY	2,123	23.7	1,654	18.5	952	10.6	533	6.0	169	1.9
ESSEX COUNTY	116,998	18.5	84,384	13.3	48,660	7.7	26,655	4.2	9,069	1.4
FRANKLIN COUNTY	12,007	18.7	8,668	13.5	5,070	7.9	2,615	4.1	983	1.5
HAMPDEN COUNTY	81,403	18.4	57,751	13.0	33,429	7.5	18,143	4.1	6,179	1.4
HAMPSHIRE COUNTY	19,894	14.3	13,826	10.0	8,255	5.9	4,148	3.0	1,423	1.0
MIDDLESEX COUNTY	218,786	16.0	158,344	11.6	90,955	6.7	51,112	3.7	16,277	1.2
NANTUCKET COUNTY	1,160	22.8	877	17.2	513	10.1	276	5.4	88	1.7
NORFOLK COUNTY	106,175	17.5	76,775	12.7	44,344	7.3	24,898	4.1	7,533	1.2
PLYMOUTH COUNTY	59,064	14.6	42,517	10.5	25,343	6.3	12,736	3.1	4,438	1.1
SUFFOLK COUNTY	114,101	17.6	84,808	13.0	48,056	7.4	27,902	4.3	8,850	1.4
WORCESTER COUNTY	116,001	17.9	83,211	12.9	48,809	7.6	25,762	4.0	8,640	1.3
MICHIGAN	1,305,636	14.1	912,258	9.8	556,510	6.0	274,095	3.0	81,653	0.9
ALCONA COUNTY	2,788	28.6	2,003	20.6	1,334	13.7	523	5.4	146	1.5
ALGER COUNTY	1,764	19.1	1,201	13.0	798	8.7	324	3.5	79	0.9
ALLEGAN COUNTY	11,741	14.4	8,391	10.3	5,088	6.2	2,487	3.0	816	1.0
ALPENA COUNTY	5,218	16.1	3,801	11.8	2,390	7.4	1,100	3.4	311	1.0
ANTRIM COUNTY	3,361	20.8	2,444	15.1	1,513	9.3	702	4.3	229	1.4
ARENAC COUNTY	2,916	19.8	2,043	13.9	1,367	9.3	541	3.7	135	0.9
BARAGA COUNTY	1,829	21.6	1,301	15.3	839	9.9	373	4.4	89	1.0
BARRY COUNTY	6,572	14.4	4,634	10.1	2,800	6.1	1,405	3.1	429	0.9

AREA NAME	POPULATION 60+ #	%	POPULATION 65+ #	%	POP 65-74 #	%	POP 75-84 #	%	POP 85+ #	%
BAY COUNTY	17,396	14.5	12,120	10.1	7,742	6.5	3,390	2.8	988	0.8
BENZIE COUNTY	2,254	20.1	1,654	14.8	1,025	9.1	463	4.1	166	1.5
BERRIEN COUNTY	26,301	15.4	18,766	11.0	11,367	6.6	5,554	3.2	1,845	1.1
BRANCH COUNTY	6,538	16.3	4,740	11.8	2,899	7.2	1,353	3.4	488	1.2
CALHOUN COUNTY	22,451	15.9	15,945	11.3	9,568	6.8	4,811	3.4	1,566	1.1
CASS COUNTY	7,693	15.5	5,407	10.9	3,410	6.9	1,547	3.1	450	0.9
CHARLEVOIX COUNTY	3,416	17.2	2,435	12.2	1,472	7.4	707	3.6	256	1.3
CHEBOYGAN COUNTY	4,024	19.5	2,884	14.0	1,886	9.1	771	3.7	227	1.1
CHIPPEWA COUNTY	5,006	17.2	3,605	12.4	2,251	7.8	1,063	3.7	291	1.0
CLARE COUNTY	5,249	22.0	3,674	15.4	2,510	10.5	919	3.9	245	1.0
CLINTON COUNTY	6,056	10.8	4,219	7.5	2,607	4.7	1,221	2.2	391	0.7
CRAWFORD COUNTY	1,733	18.3	1,187	12.5	794	8.4	313	3.3	80	0.8
DELTA COUNTY	6,765	17.4	4,943	12.7	2,989	7.7	1,512	3.9	442	1.1
DICKINSON COUNTY	5,694	22.5	4,268	16.8	2,421	9.6	1,459	5.8	388	1.5
EATON COUNTY	9,925	11.2	7,023	8.0	4,187	4.7	2,115	2.4	721	0.8
EMMET COUNTY	3,936	17.1	2,882	12.5	1,676	7.3	901	3.9	305	1.3
GENESEE COUNTY	51,262	11.4	35,835	8.0	21,714	4.8	11,169	2.5	2,952	0.7
GLADWIN COUNTY	4,117	20.6	2,851	14.3	1,927	9.7	712	3.6	212	1.1
GOGEBIC COUNTY	5,508	28.0	4,079	20.7	2,534	12.9	1,198	6.1	347	1.8
GRAND TRAVERSE COUNTY	7,990	14.6	5,900	10.7	3,596	6.6	1,742	3.2	562	1.0
GRATIOT COUNTY	6,447	15.9	4,725	11.7	2,632	6.5	1,458	3.6	635	1.6
HILLSDALE COUNTY	7,048	16.8	5,160	12.3	3,057	7.3	1,590	3.8	513	1.2
HOUGHTON COUNTY	8,130	21.5	6,046	16.0	3,914	10.3	1,663	4.4	469	1.2
HURON COUNTY	7,692	21.1	5,508	15.1	3,407	9.3	1,613	4.4	488	1.3
INGHAM COUNTY	28,942	10.5	20,512	7.4	11,807	4.3	6,646	2.4	2,059	0.7
IONIA COUNTY	6,901	13.3	4,986	9.6	2,879	5.6	1,626	3.1	481	0.9
IOSCO COUNTY	5,301	18.7	3,818	13.5	2,499	8.8	1,036	3.7	283	1.0
IRON COUNTY	4,076	29.9	2,986	21.9	1,921	14.1	793	5.8	272	2.0
ISABELLA COUNTY	5,448	10.1	3,827	7.1	2,377	4.4	1,117	2.1	333	0.6
JACKSON COUNTY	21,387	14.1	15,038	9.9	8,901	5.9	4,709	3.1	1,428	0.9
KALAMAZOO COUNTY	26,696	12.6	18,909	8.9	11,087	5.2	5,873	2.8	1,949	0.9
KALKASKA COUNTY	1,811	16.5	1,276	11.7	863	7.9	320	2.9	93	0.8
KENT COUNTY	62,780	14.1	45,414	10.2	26,422	5.9	14,307	3.2	4,685	1.1
KEWEENAW COUNTY	713	36.3	543	27.7	402	20.5	114	5.8	27	1.4
LAKE COUNTY	2,274	29.5	1,626	21.1	1,075	13.9	448	5.8	103	1.3
LAPEER COUNTY	7,243	10.3	5,004	7.1	3,158	4.5	1,424	2.0	423	0.6
LEELANAU COUNTY	2,599	18.6	1,865	13.3	1,184	8.5	520	3.7	161	1.1
LENAWEE COUNTY	13,114	14.6	9,171	10.2	5,464	6.1	2,721	3.0	986	1.1
LIVINGSTON COUNTY	10,202	10.2	7,042	7.0	4,328	4.3	2,052	2.0	662	0.7
LUCE COUNTY	1,282	19.3	912	13.7	592	8.9	252	3.8	68	1.0
MACKINAC COUNTY	2,083	20.5	1,528	15.0	1,000	9.8	422	4.1	106	1.0
MACOMB COUNTY	81,877	11.8	53,495	7.7	34,183	4.9	15,289	2.2	4,023	0.6
MANISTEE COUNTY	4,850	21.1	3,580	15.6	2,174	9.4	1,076	4.7	330	1.4
MARQUETTE COUNTY	9,170	12.4	6,540	8.8	4,173	5.6	1,826	2.5	541	0.7
MASON COUNTY	5,373	20.4	3,929	14.9	2,321	8.8	1,211	4.6	397	1.5
MECOSTA COUNTY	4,858	13.1	3,350	9.1	2,094	5.7	963	2.6	293	0.8
MENOMINEE COUNTY	5,131	19.6	3,704	14.1	2,292	8.7	1,136	4.3	276	1.1
MIDLAND COUNTY	7,925	10.8	5,356	7.3	3,349	4.6	1,527	2.1	480	0.7
MISSAUKEE COUNTY	1,767	17.7	1,247	12.5	823	8.2	347	3.5	77	0.8
MONROE COUNTY	16,145	12.0	11,287	8.4	6,947	5.2	3,393	2.5	947	0.7
MONTCALM COUNTY	8,057	16.9	5,786	12.2	3,565	7.5	1,688	3.5	533	1.1
MONTMORENCY COUNTY	1,916	25.6	1,333	17.8	914	12.2	355	4.7	64	0.9
MUSKEGON COUNTY	24,249	15.4	16,863	10.7	10,422	6.6	4,953	3.1	1,488	0.9
NEWAYGO COUNTY	6,331	18.1	4,570	13.1	2,909	8.3	1,272	3.6	389	1.1
OAKLAND COUNTY	131,317	13.0	89,793	8.9	54,609	5.4	27,561	2.7	7,623	0.8
OCEANA COUNTY	3,752	17.1	2,717	12.3	1,682	7.6	764	3.5	271	1.2
OGEMAW COUNTY	3,588	21.8	2,507	15.3	1,676	10.2	670	4.1	161	1.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ONTONAGON COUNTY	2,186	22.2	1,572	15.9	1,108	11.2	381	3.9	83	0.8
OSCEOLA COUNTY	3,445	18.2	2,496	13.2	1,526	8.1	784	4.1	186	1.0
OSCODA COUNTY	1,703	24.8	1,212	17.7	764	11.1	334	4.9	114	1.7
OTSEGO COUNTY	2,293	15.3	1,634	10.9	990	6.6	501	3.3	143	1.0
OTTAWA COUNTY	19,370	12.3	13,707	8.7	8,320	5.3	4,041	2.6	1,346	0.9
PRESQUE ISLE COUNTY	2,973	20.8	2,143	15.0	1,402	9.8	588	4.1	153	1.1
ROSCOMMON COUNTY	4,649	28.4	3,184	19.4	2,262	13.8	775	4.7	147	0.9
SAGINAW COUNTY	29,789	13.1	21,000	9.2	12,957	5.7	6,098	2.7	1,945	0.9
ST. CLAIR COUNTY	20,782	15.0	14,810	10.7	9,027	6.5	4,528	3.3	1,255	0.9
ST. JOSEPH COUNTY	9,196	16.4	6,698	11.9	4,126	7.4	1,981	3.5	591	1.1
SANILAC COUNTY	7,864	19.3	5,675	13.9	3,469	8.5	1,720	4.2	486	1.2
SCHOOLCRAFT COUNTY	1,804	21.0	1,320	15.4	801	9.3	411	4.8	108	1.3
SHIAWASSEE COUNTY	8,789	12.4	6,178	8.7	3,661	5.1	1,943	2.7	574	0.8
TUSCOLA COUNTY	7,820	13.7	5,486	9.6	3,386	5.9	1,564	2.7	536	0.9
VAN BUREN COUNTY	11,039	16.5	8,132	12.2	4,799	7.2	2,480	3.7	853	1.3
WASHTENAW COUNTY	24,186	9.1	16,853	6.4	9,663	3.6	5,362	2.0	1,828	0.7
WAYNE COUNTY	355,224	15.2	244,663	10.5	148,450	6.3	74,496	3.2	21,717	0.9
WEXFORD COUNTY	4,546	18.1	3,307	13.2	1,993	7.9	998	4.0	316	1.3
MINNESOTA	680,202	16.0	479,564	11.8	270,148	6.6	156,627	3.8	52,789	1.3
AITKIN COUNTY	3,509	26.2	2,605	19.4	1,582	11.8	782	5.8	241	1.8
ANOKA COUNTY	12,711	6.5	8,197	4.2	5,258	2.7	2,272	1.2	667	0.3
BECKER COUNTY	5,726	19.5	4,280	14.6	2,460	8.4	1,379	4.7	441	1.5
BELTRAMI COUNTY	4,557	14.7	3,389	10.9	2,025	6.5	1,034	3.3	330	1.1
BENTON COUNTY	3,682	14.6	2,770	11.0	1,397	5.5	1,001	4.0	372	1.5
BIG STONE COUNTY	2,011	26.1	1,582	20.5	809	10.5	578	7.5	195	2.5
BLUE EARTH COUNTY	8,113	15.5	6,025	11.5	3,256	6.2	2,030	3.9	739	1.4
BROWN COUNTY	5,893	20.6	4,473	15.6	2,500	8.7	1,517	5.3	456	1.6
CARLTON COUNTY	5,205	17.4	3,804	12.7	2,286	7.6	1,136	3.8	382	1.3
CARVER COUNTY	4,435	12.0	3,296	8.9	1,882	5.1	1,117	3.0	297	0.8
CASS COUNTY	5,316	25.3	3,921	18.6	2,458	11.7	1,113	5.3	350	1.7
CHIPPEWA COUNTY	3,411	22.8	2,663	17.8	1,412	9.5	949	6.4	302	2.0
CHISAGO COUNTY	4,119	16.0	3,098	12.0	1,764	6.9	988	3.8	346	1.3
CLAY COUNTY	6,807	13.8	4,947	10.0	2,704	5.5	1,696	3.4	547	1.1
CLEARWATER COUNTY	1,974	22.5	1,521	17.4	832	9.5	533	6.1	156	1.8
COOK COUNTY	832	20.3	609	14.9	388	9.5	158	3.9	63	1.5
COTTONWOOD COUNTY	3,538	23.8	2,778	18.7	1,514	10.2	960	6.5	304	2.0
CROW WING COUNTY	8,859	21.2	6,511	15.6	4,059	9.7	1,949	4.7	503	1.2
DAKOTA COUNTY	16,866	8.7	11,526	5.9	7,055	3.6	3,440	1.8	1,031	0.5
DODGE COUNTY	2,505	17.0	1,880	12.7	962	6.5	674	4.6	244	1.7
DOUGLAS COUNTY	5,865	21.1	4,429	15.9	2,431	8.7	1,474	5.3	524	1.9
FARIBAULT COUNTY	4,751	24.1	3,593	18.2	1,922	9.7	1,252	6.4	419	2.1
FILLMORE COUNTY	5,199	23.7	3,987	18.2	2,058	9.4	1,413	6.4	516	2.4
FREEBORN COUNTY	7,369	20.3	5,471	15.1	2,992	8.2	1,808	5.0	671	1.8
GOODHUE COUNTY	7,842	20.2	6,104	15.8	3,266	8.4	2,048	5.3	790	2.0
GRANT COUNTY	1,970	27.5	1,535	21.4	826	11.5	526	7.3	183	2.6
HENNEPIN COUNTY	140,337	14.9	102,062	10.8	56,150	6.0	34,128	3.6	11,784	1.3
HOUSTON COUNTY	3,560	19.4	2,717	14.8	1,447	7.9	915	5.0	355	1.9
HUBBARD COUNTY	3,078	21.8	2,306	16.4	1,440	10.2	654	4.6	212	1.5
ISANTI COUNTY	3,332	14.1	2,548	10.8	1,428	6.1	820	3.5	300	1.3
ITASCA COUNTY	7,520	17.5	5,326	12.4	3,396	7.9	1,504	3.5	426	1.0
JACKSON COUNTY	2,971	21.7	2,221	16.2	1,182	8.6	751	5.5	288	2.1
KANABEC COUNTY	2,323	19.1	1,708	14.0	1,009	8.3	549	4.5	150	1.2
KANDIYOHI COUNTY	6,865	18.7	5,081	13.8	2,826	7.7	1,666	4.5	589	1.6
KITTSON COUNTY	1,655	24.8	1,264	18.9	660	9.9	434	6.5	170	2.5
KOOCHICHING COUNTY	2,900	16.5	2,046	11.6	1,315	7.5	563	3.2	168	1.0
LAC QUI PARLE COUNTY	2,646	25.0	2,044	19.3	1,088	10.3	720	6.8	236	2.2
LAKE COUNTY	2,068	15.9	1,466	11.2	920	7.1	425	3.3	121	0.9

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
LAKE OF THE WOODS COUNTY	828	22.0	620	16.5	407	10.8	156	4.1	57	1.5
LE SUEUR COUNTY	4,490	19.2	3,390	14.5	1,847	7.9	1,212	5.2	331	1.4
LINCOLN COUNTY	2,068	25.2	1,575	19.2	841	10.2	534	6.5	200	2.4
LYON COUNTY	4,532	18.0	3,382	13.4	1,875	7.4	1,119	4.4	388	1.5
MCLEOD COUNTY	5,529	18.6	4,155	14.0	2,330	7.9	1,382	4.7	443	1.5
MAHNOMEN COUNTY	1,147	20.7	869	15.7	521	9.4	262	4.7	86	1.6
MARSHALL COUNTY	2,649	20.3	1,953	15.0	1,072	8.2	685	5.3	196	1.5
MARTIN COUNTY	5,453	22.1	4,143	16.8	2,305	9.3	1,382	5.6	456	1.8
MEEKER COUNTY	4,376	21.2	3,312	16.1	1,861	9.0	1,097	5.3	354	1.7
MILLE LACS COUNTY	3,949	21.4	3,044	16.5	1,721	9.3	998	5.4	325	1.8
MORRISON COUNTY	5,482	18.7	4,102	14.0	2,309	7.9	1,374	4.7	419	1.4
MOWER COUNTY	8,726	21.6	6,367	15.8	3,681	9.1	2,033	5.0	653	1.6
MURRAY COUNTY	2,471	21.5	1,811	15.7	1,024	8.9	601	5.2	186	1.6
NICOLLET COUNTY	3,727	13.8	2,818	10.5	1,590	5.9	920	3.4	309	1.1
NOBLES COUNTY	4,513	20.7	3,409	15.6	1,854	8.5	1,153	5.3	402	1.8
NORMAN COUNTY	2,442	26.0	1,933	20.6	972	10.4	708	7.5	253	2.7
OLMSTED COUNTY	11,590	12.6	8,574	9.3	4,702	5.1	2,872	3.1	1,000	1.1
OTTER TAIL COUNTY	12,300	23.7	9,327	18.0	5,253	10.1	3,018	5.8	1,056	2.0
PENNINGTON COUNTY	2,861	18.8	2,203	14.4	1,177	7.7	743	4.9	283	1.9
PINE COUNTY	4,001	20.1	3,004	15.1	1,773	8.9	992	5.0	239	1.2
PIPESTONE COUNTY	2,761	23.6	2,158	18.5	1,133	9.7	774	6.6	251	2.1
POLK COUNTY	7,086	20.3	5,360	15.4	2,925	8.4	1,748	5.0	687	2.0
POPE COUNTY	2,912	25.0	2,217	19.0	1,201	10.3	756	6.5	260	2.2
RAMSEY COUNTY	72,619	15.8	53,326	11.6	29,512	6.4	17,695	3.8	6,119	1.3
RED LAKE COUNTY	1,120	20.5	844	15.4	466	8.5	300	5.5	78	1.4
REDWOOD COUNTY	4,502	23.3	3,401	17.6	1,822	9.4	1,150	5.9	429	2.2
RENVILLE COUNTY	4,706	23.1	3,539	17.3	1,897	9.3	1,232	6.0	410	2.0
RICE COUNTY	7,005	15.2	5,312	11.5	2,884	6.3	1,806	3.9	622	1.3
ROCK COUNTY	2,262	21.1	1,655	15.5	900	8.4	547	5.1	208	1.9
ROSEAU COUNTY	2,482	19.7	1,882	15.0	1,105	8.8	587	4.7	190	1.5
ST. LOUIS COUNTY	41,182	18.5	30,026	13.5	18,165	8.2	8,849	4.0	3,012	1.4
SCOTT COUNTY	4,492	10.3	3,236	7.4	1,783	4.1	1,055	2.4	398	0.9
SHERBURNE COUNTY	3,286	11.0	2,440	8.2	1,293	4.3	782	2.6	365	1.2
SIBLEY COUNTY	3,393	22.0	2,542	16.5	1,442	9.3	837	5.4	263	1.7
STEARNS COUNTY	14,287	13.2	10,549	9.8	6,163	5.7	3,422	3.2	964	0.9
STEELE COUNTY	5,122	16.9	3,824	12.6	2,119	7.0	1,254	4.1	451	1.5
STEVENS COUNTY	2,121	18.7	1,595	14.1	865	7.6	532	4.7	198	1.7
SWIFT COUNTY	3,007	23.3	2,264	17.5	1,257	9.7	763	5.9	244	1.9
TODD COUNTY	5,149	20.6	3,870	15.5	2,184	8.7	1,307	5.2	379	1.5
TRAVERSE COUNTY	1,449	26.1	1,139	20.6	603	10.9	388	7.0	148	2.7
WABASHA COUNTY	3,928	20.3	2,972	15.4	1,673	8.7	961	5.0	338	1.7
WADENA COUNTY	3,043	21.4	2,328	16.4	1,270	8.9	773	5.4	285	2.0
WASECA COUNTY	3,350	18.2	2,492	13.5	1,326	7.2	858	4.7	308	1.7
WASHINGTON COUNTY	9,474	8.3	6,564	5.8	3,839	3.4	2,041	1.8	684	0.6
WATONWAN COUNTY	2,838	23.0	2,161	17.5	1,196	9.7	733	5.9	232	1.9
WILKIN COUNTY	1,726	20.4	1,315	15.6	705	8.3	469	5.5	141	1.7
WINONA COUNTY	8,116	17.5	6,244	13.5	3,450	7.5	2,059	4.5	735	1.6
WRIGHT COUNTY	8,090	13.8	6,036	10.3	3,555	6.1	1,882	3.2	599	1.0
YELLOW MEDICINE COUNTY	3,240	23.7	2,498	18.3	1,341	9.8	870	6.4	287	2.1
MISSISSIPPI	393,021	15.6	289,357	11.5	179,949	7.1	85,899	3.4	23,509	0.9
ADAMS COUNTY	6,018	15.8	4,323	11.4	2,592	6.8	1,334	3.5	397	1.0
ALCORN COUNTY	5,652	17.1	4,166	12.6	2,574	7.8	1,282	3.9	310	0.9
AMITE COUNTY	2,665	19.9	1,975	14.8	1,231	9.2	592	4.4	152	1.1
ATTALA COUNTY	4,372	22.0	3,316	16.7	1,971	9.9	1,045	5.3	300	1.5
BENTON COUNTY	1,518	18.6	1,155	14.2	767	9.4	314	3.9	74	0.9
BOLIVAR COUNTY	7,334	16.0	5,538	12.0	3,4[illegible]	7.4	1,583	3.4	552	1.2
CALHOUN COUNTY	3,168	20.2	2,383	15.2	1,528	9.8	689	4.4	166	1.1

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
CARROLL COUNTY	1,966	20.1	1,440	14.7	924	9.5	395	4.0	121	1.2
CHICKASAW COUNTY	3,132	17.5	2,353	13.2	1,422	8.0	715	4.0	216	1.2
CHOCTAW COUNTY	1,773	19.7	1,374	15.3	832	9.2	431	4.8	111	1.2
CLAIBORNE COUNTY	2,000	16.3	1,495	12.2	952	7.8	404	3.3	139	1.1
CLARKE COUNTY	3,257	19.2	2,441	14.4	1,509	8.9	764	4.5	168	1.0
CLAY COUNTY	3,365	16.0	2,493	11.8	1,513	7.2	737	3.5	243	1.2
COAHOMA COUNTY	6,359	17.2	4,825	13.1	2,948	8.0	1,462	4.0	415	1.1
COPIAH COUNTY	4,898	18.5	3,751	14.2	2,310	8.7	1,152	4.3	289	1.1
COVINGTON COUNTY	2,833	17.8	2,118	13.3	1,352	8.5	602	3.8	164	1.0
DE SOTO COUNTY	5,425	10.1	3,717	6.9	2,366	4.4	1,053	2.0	298	0.6
FORREST COUNTY	9,938	15.1	7,273	11.0	4,484	6.8	2,170	3.3	619	0.9
FRANKLIN COUNTY	1,702	20.7	1,289	15.7	772	9.4	419	5.1	98	1.2
GEORGE COUNTY	2,176	14.2	1,598	10.4	1,035	6.8	436	2.9	127	0.8
GREENE COUNTY	1,562	15.9	1,157	11.8	699	7.1	376	3.8	82	0.8
GRENADA COUNTY	3,564	16.9	2,609	12.4	1,611	7.7	763	3.6	235	1.1
HANCOCK COUNTY	4,116	16.8	2,883	11.7	1,943	7.9	768	3.1	172	0.7
HARRISON COUNTY	19,473	12.4	13,671	8.7	8,725	5.5	3,964	2.5	982	0.5
HINDS COUNTY	33,362	13.3	24,172	9.6	15,264	6.1	7,039	2.8	1,869	0.7
HOLMES COUNTY	4,452	19.4	3,408	14.8	2,066	9.0	1,046	4.6	296	1.3
HUMPHREYS COUNTY	2,457	17.6	1,828	13.1	1,124	8.1	555	4.0	149	1.1
ISSAQUENA COUNTY	375	14.9	275	10.9	171	6.8	84	3.3	20	0.8
ITAWAMBA COUNTY	3,750	18.3	2,785	13.6	1,774	8.6	821	4.0	190	0.9
JACKSON COUNTY	11,310	9.6	7,447	6.3	5,070	4.3	1,838	1.6	539	0.5
JASPER COUNTY	3,118	18.1	2,369	13.7	1,429	8.3	735	4.3	205	1.2
JEFFERSON COUNTY	1,610	17.5	1,257	13.7	703	7.7	429	4.7	125	1.4
JEFFERSON DAVIS COUNTY	2,471	17.8	1,791	12.9	1,131	8.2	544	3.9	116	0.8
JONES COUNTY	10,795	17.4	7,977	12.9	5,032	8.1	2,311	3.7	634	1.0
KEMPER COUNTY	2,040	20.1	1,574	15.5	917	9.0	519	5.1	138	1.4
LAFAYETTE COUNTY	4,593	14.8	3,284	10.6	1,947	6.3	1,106	3.6	231	0.7
LAMAR COUNTY	2,931	12.3	2,050	8.6	1,327	5.6	586	2.5	137	0.6
LAUDERDALE COUNTY	13,061	16.9	9,621	12.4	5,837	7.6	2,934	3.8	850	1.1
LAWRENCE COUNTY	2,073	16.6	1,595	12.7	1,018	8.1	462	3.7	115	0.9
LEAKE COUNTY	3,943	21.0	3,007	16.0	1,842	9.8	911	4.8	254	1.4
LEE COUNTY	8,548	15.0	6,233	10.9	3,935	6.9	1,811	3.2	487	0.9
LEFLORE COUNTY	6,996	16.8	5,245	12.6	3,161	7.6	1,630	3.9	454	1.1
LINCOLN COUNTY	5,350	17.7	4,018	13.3	2,485	8.2	1,222	4.0	311	1.0
LOWNDES COUNTY	7,297	12.7	5,305	9.3	3,328	5.8	1,494	2.6	483	0.8
MADISON COUNTY	5,835	14.0	4,340	10.4	2,644	6.4	1,338	3.2	358	0.9
MARION COUNTY	4,543	17.7	3,324	12.9	2,117	8.2	926	3.6	281	1.1
MARSHALL COUNTY	4,140	14.1	3,005	10.3	1,856	6.3	883	3.0	266	0.9
MONROE COUNTY	6,327	17.4	4,696	12.9	2,907	8.0	1,397	3.8	392	1.1
MONTGOMERY COUNTY	2,973	22.2	2,276	17.0	1,384	10.4	713	5.3	179	1.3
NESHOBA COUNTY	4,353	18.3	3,325	14.0	2,016	8.5	1,028	4.3	281	1.2
NEWTON COUNTY	4,140	20.8	3,175	15.9	1,914	9.6	1,001	5.0	260	1.3
NOXUBEE COUNTY	2,383	18.0	1,803	13.6	1,128	8.5	540	4.1	135	1.0
OKTIBBEHA COUNTY	3,872	10.8	2,911	8.1	1,730	4.8	905	2.5	276	0.8
PANOLA COUNTY	5,178	18.4	3,897	13.8	2,433	8.6	1,157	4.1	307	1.1
PEARL RIVER COUNTY	4,731	14.0	3,375	10.0	2,146	6.4	985	2.9	244	0.7
PERRY COUNTY	1,433	14.5	1,071	10.9	688	7.0	306	3.1	77	0.8
PIKE COUNTY	6,674	18.5	4,995	13.8	3,079	8.5	1,561	4.3	355	1.0
PONTOTOC COUNTY	3,997	19.1	2,960	14.2	1,836	8.8	884	4.2	240	1.1
PRENTISS COUNTY	4,393	18.3	3,253	13.5	2,049	8.5	969	4.0	235	1.0
QUITMAN COUNTY	2,375	18.8	1,796	14.2	1,122	8.9	521	4.1	153	1.2
RANKIN COUNTY	7,608	11.0	5,367	7.7	3,512	5.1	1,496	2.2	359	0.5
SCOTT COUNTY	4,136	16.8	3,133	12.8	1,931	7.9	933	3.8	269	1.1
SHARKEY COUNTY	1,269	15.9	935	11.7	575	7.2	278	3.5	82	1.0
SIMPSON COUNTY	4,099	17.5	3,094	13.2	1,872	8.0	969	4.1	253	1.1

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
SMITH COUNTY	2,702	17.8	1,995	13.2	1,294	8.6	552	3.7	149	1.0
STONE COUNTY	1,473	15.2	1,053	10.8	647	6.7	305	3.1	101	1.0
SUNFLOWER COUNTY	5,559	16.0	4,228	12.1	2,625	7.5	1,228	3.5	375	1.1
TALLAHATCHIE COUNTY	3,162	18.4	2,382	13.9	1,492	8.7	728	4.2	162	0.9
TATE COUNTY	3,152	15.7	2,328	11.6	1,497	7.4	641	3.2	190	0.9
TIPPAH COUNTY	3,722	19.9	2,806	15.0	1,736	9.3	825	4.4	245	1.3
TISHOMINGO COUNTY	3,435	18.6	2,508	13.6	1,592	8.6	743	4.0	173	0.9
TUNICA COUNTY	1,650	17.1	1,250	13.0	716	7.4	418	4.3	116	1.2
UNION COUNTY	4,330	19.9	3,229	14.9	1,944	8.9	1,026	4.7	259	1.2
WALTHALL COUNTY	2,576	18.7	1,933	14.0	1,226	8.9	561	4.1	146	1.1
WARREN COUNTY	7,957	15.4	5,810	11.3	3,487	6.8	1,757	3.4	566	1.1
WASHINGTON COUNTY	10,969	15.2	8,123	11.2	5,077	7.0	2,345	3.2	701	1.0
WAYNE COUNTY	2,832	14.8	2,086	10.9	1,269	6.6	664	3.5	153	0.8
WEBSTER COUNTY	2,352	22.8	1,821	17.7	1,082	10.5	572	5.6	167	1.6
WILKINSON COUNTY	2,085	20.8	1,553	15.5	915	9.1	485	4.8	153	1.5
WINSTON COUNTY	3,807	19.5	2,931	15.1	1,800	9.2	900	4.6	231	1.2
YALOBUSHA COUNTY	2,896	22.0	2,184	16.6	1,308	10.0	678	5.2	198	1.5
YAZOO COUNTY	5,099	18.6	3,822	14.0	2,279	8.3	1,154	4.2	389	1.4
MISSOURI	873,358	17.8	648,126	13.2	381,060	7.8	205,994	4.2	61,072	1.2
ADAIR COUNTY	4,074	16.4	3,114	12.5	1,757	7.1	1,007	4.0	350	1.4
ANDREW COUNTY	2,770	19.8	2,081	14.9	1,137	8.1	701	5.0	243	1.7
ATCHISON COUNTY	2,125	24.7	1,648	19.2	873	10.1	543	6.3	232	2.7
AUDRAIN COUNTY	5,514	20.8	4,065	15.4	2,306	8.7	1,319	5.0	440	1.7
BARRY COUNTY	6,151	25.2	4,636	19.0	2,903	11.9	1,382	5.7	351	1.4
BARTON COUNTY	2,945	26.1	2,326	20.6	1,261	11.2	815	7.2	250	2.2
BATES COUNTY	4,123	26.0	3,190	20.1	1,777	11.2	1,048	6.6	365	2.3
BENTON COUNTY	3,590	29.5	2,624	21.5	1,672	13.7	752	6 2	200	1.6
BOLLINGER COUNTY	2,228	21.6	1,651	16.0	1,039	10.1	482	4.7	130	1.3
BOONE COUNTY	10,439	10.4	7,592	7.6	4,329	4.3	2,441	2.4	822	0.8
BUCHANAN COUNTY	17,883	20.3	13,443	15.3	7,552	8.6	4,536	5.2	1,355	1.5
BUTLER COUNTY	7,538	20.0	5,643	15.0	3,501	9.3	1,699	4.5	443	1.2
CALDWELL COUNTY	2,239	25.9	1,765	20.4	903	10.4	636	7.3	226	2.6
CALLAWAY COUNTY	5,186	16.1	3,907	12.1	2,282	7.1	1,217	3.8	408	1.3
CAMDEN COUNTY	4,938	24.7	3,417	17.1	2,381	11.9	851	4.3	185	0.9
CAPE GIRARDEAU COUNTY	9,834	16.7	7,360	12.5	4,242	7.2	2,418	4.1	700	1.2
CARROLL COUNTY	3,039	25.1	2,406	19.8	1,328	10.9	854	7.0	224	1.8
CARTER COUNTY	1,073	19.8	815	15.0	495	9.1	254	4.7	66	1.2
CASS COUNTY	6,603	12.9	4,786	9.4	2,751	5.4	1,595	3.1	440	0.9
CEDAR COUNTY	3,586	30.1	2,782	23.4	1,694	14.2	842	7.1	246	2.1
CHARITON COUNTY	2,820	26.9	2,179	20.8	1,242	11.8	700	6.7	237	2.3
CHRISTIAN COUNTY	3,588	16.0	2,631	11.7	1,611	7.2	795	3.5	225	1.0
CLARK COUNTY	1,830	21.5	1,423	16.8	786	9.3	492	5.8	145	1.7
CLAY COUNTY	15,819	11.6	10,654	7.8	6,650	4.9	3,048	2.2	956	0.7
CLINTON COUNTY	2,987	18.8	2,311	14.5	1,248	7.8	763	4.8	300	1.9
COLE COUNTY	8,374	14.8	6,097	10.8	3,628	6.4	1,885	3.3	584	1.0
COOPER COUNTY	3,368	23.0	2,502	17.1	1,425	9.7	779	5.3	298	2.0
CRAWFORD COUNTY	4,090	22.3	3,143	17.2	1,888	10.3	985	5.4	270	1.5
DADE COUNTY	2,211	29.9	1,728	23.4	937	12.7	596	8.1	195	2.6
DALLAS COUNTY	3,039	25.1	2,314	19.1	1,410	11.7	733	6.1	171	1.4
DAVIESS COUNTY	2,318	26.0	1,778	20.0	997	11.2	591	6.6	190	2.1
DE KALB COUNTY	1,983	24.1	1,558	18.9	771	9.4	582	7.1	205	2.5
DENT COUNTY	3,244	22.3	2,426	16.7	1,462	10.1	744	5.1	220	1.5
DOUGLAS COUNTY	2,458	21.2	1,849	15.9	1,098	9.5	589	5.1	162	1.4
DUNKLIN COUNTY	7,648	21.1	5,750	15.8	3,524	9.7	1,773	4.9	453	1.2
FRANKLIN COUNTY	11,252	15.8	8,324	11.7	5,064	7.1	2,580	3.6	680	1.0
GASCONADE COUNTY	3,566	27.1	2,719	20.6	1,539	11.7	902	6.8	278	2.1
GENTRY COUNTY	2,342	29.7	1,855	23.5	932	11.8	663	8.4	260	3.3

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
GREENE COUNTY	29,656	16.0	22,067	11.9	12,802	6.9	7,106	3.8	2,159	1.2
GRUNDY COUNTY	3,058	25.6	2,363	19.8	1,265	10.6	842	7.0	256	2.1
HARRISON COUNTY	2,839	28.7	2,235	22.6	1,275	12.9	781	7.9	179	1.8
HENRY COUNTY	5,189	26.4	4,067	20.7	2,231	11.3	1,384	7.0	452	2.3
HICKORY COUNTY	2,064	32.4	1,451	22.8	978	15.4	399	6.3	74	1.2
HOLT COUNTY	1,984	28.8	1,538	22.3	875	12.7	499	7.3	164	2.4
HOWARD COUNTY	2,422	24.2	1,938	19.4	1,021	10.2	680	6.8	237	2.4
HOWELL COUNTY	6,146	21.3	4,598	16.0	2,769	9.6	1,444	5.0	385	1.3
IRON COUNTY	2,411	21.8	1,832	16.5	1,067	9.6	549	5.0	216	1.9
JACKSON COUNTY	102,785	16.3	75,613	12.0	43,379	6.9	24,739	3.9	7,495	1.2
JASPER COUNTY	17,253	19.8	12,880	14.8	7,549	8.7	4,102	4.7	1,229	1.4
JEFFERSON COUNTY	15,287	10.5	10,648	7.3	6,771	4.6	2,953	2.0	924	0.6
JOHNSON COUNTY	4,829	12.4	3,594	9.2	2,011	5.1	1,181	3.0	402	1.0
KNOX COUNTY	1,463	26.6	1,154	21.0	637	11.6	372	6.8	145	2.6
LACLEDE COUNTY	4,892	20.1	3,630	14.9	2,255	9.3	1,078	4.4	297	1.2
LAFAYETTE COUNTY	6,458	21.6	4,983	16.7	2,687	9.0	1,680	5.6	616	2.1
LAWRENCE COUNTY	6,623	22.9	5,130	17.7	2,934	10.1	1,724	6.0	472	1.6
LEWIS COUNTY	2,317	21.3	1,801	16.5	952	8.7	621	5.7	228	2.1
LINCOLN COUNTY	4,238	19.1	3,255	14.7	1,844	8.3	1,069	4.8	342	1.5
LINN COUNTY	4,420	28.5	3,452	22.3	1,867	12.0	1,184	7.6	401	2.6
LIVINGSTON COUNTY	3,633	23.1	2,839	18.0	1,472	9.4	967	6.1	400	2.5
MCDONALD COUNTY	2,971	19.9	2,222	14.9	1,383	9.3	690	4.6	149	1.0
MACON COUNTY	4,239	26.0	3,266	20.0	1,872	11.5	1,068	6.5	326	2.0
MADISON COUNTY	2,753	25.7	2,090	19.5	1,272	11.9	642	6.0	176	1.6
MARIES COUNTY	1,665	22.1	1,237	16.4	779	10.3	378	5.0	80	1.1
MARION COUNTY	6,309	22.0	4,907	17.1	2,684	9.4	1,666	5.8	557	1.9
MERCER COUNTY	1,399	29.9	1,091	23.3	653	13.9	345	7.4	93	2.0
MILLER COUNTY	3,896	21.0	2,936	15.8	1,755	9.5	906	4.9	275	1.5
MISSISSIPPI COUNTY	3,159	20.1	2,365	15.0	1,420	9.0	711	4.5	234	1.5
MONITEAU COUNTY	2,631	21.8	2,040	16.9	1,117	9.3	691	5.7	232	1.9
MONROE COUNTY	2,353	24.2	1,812	18.6	1,010	10.4	594	6.1	208	2.1
MONTGOMERY COUNTY	2,883	25.0	2,227	19.3	1,250	10.8	700	6.1	277	2.4
MORGAN COUNTY	3,759	27.2	2,815	20.4	1,715	12.4	844	6.1	256	1.9
NEW MADRID COUNTY	4,237	18.5	3,157	13.8	1,992	8.7	921	4.0	244	1.1
NEWTON COUNTY	7,596	18.7	5,558	13.7	3,471	8.6	1,674	4.1	413	1.0
NODAWAY COUNTY	4,334	19.7	3,390	15.4	1,874	8.5	1,102	5.0	414	1.9
OREGON COUNTY	2,570	25.1	1,937	18.9	1,197	11.7	545	5.3	195	1.9
OSAGE COUNTY	2,372	19.7	1,823	15.2	1,102	9.2	575	4.8	146	1.2
OZARK COUNTY	1,949	24.5	1,434	18.0	968	12.2	380	4.8	86	1.1
PEMISCOT COUNTY	5,132	20.5	3,841	15.4	2,288	9.2	1,169	4.7	384	1.5
PERRY COUNTY	3,645	21.7	2,799	16.7	1,598	9.5	911	5.4	290	1.7
PETTIS COUNTY	7,667	21.1	5,865	16.1	3,215	8.8	2,001	5.5	649	1.8
PHELPS COUNTY	5,534	16.5	4,124	12.3	2,441	7.3	1,265	3.8	418	1.2
PIKE COUNTY	3,538	20.7	2,820	16.1	1,591	9.1	915	5.2	314	1.8
PLATTE COUNTY	4,603	9.9	3,009	6.5	1,906	4.1	846	1.8	257	0.6
POLK COUNTY	4,218	22.4	3,238	17.2	1,817	9.7	1,084	5.8	337	1.8
PULASKI COUNTY	3,310	7.9	2,359	5.6	1,452	3.5	706	1.7	201	0.5
PUTNAM COUNTY	1,702	27.9	1,323	21.7	741	12.2	429	7.0	153	2.5
RALLS COUNTY	1,824	20.5	1,384	15.5	842	9.4	402	4.5	140	1.6
RANDOLPH COUNTY	5,375	21.1	4,234	16.6	2,305	9.1	1,473	5.8	456	1.8
RAY COUNTY	3,761	17.6	2,829	13.2	1,593	7.5	914	4.3	322	1.5
REYNOLDS COUNTY	1,456	20.1	1,065	14.7	663	9.2	333	4.6	69	1.0
RIPLEY COUNTY	3,039	24.4	2,286	18.3	1,488	11.9	621	5.0	177	1.4
ST. CHARLES COUNTY	12,738	8.8	8,684	6.0	5,232	3.6	2,665	1.8	787	0.5
ST. CLAIR COUNTY	2,561	29.7	1,979	23.0	1,102	12.8	653	7.6	224	2.6
STE. GENEVIEVE COUNTY	2,589	17.1	1,925	12.7	1,162	7.7	580	3.8	183	1.2
ST. FRANCOIS COUNTY	8,879	20.8	6,629	15.6	4,095	9.6	1,999	4.7	535	1.3

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ST. LOUIS COUNTY	145,081	14.9	102,395	10.5	62,716	6.4	31,186	3.2	8,493	0.9
SALINE COUNTY	5,694	22.9	4,369	17.5	2,396	9.6	1,476	5.9	497	2.0
SCHUYLER COUNTY	1,337	26.9	1,038	20.8	574	11.5	351	7.0	113	2.3
SCOTLAND COUNTY	1,481	27.3	1,168	21.6	616	11.4	382	7.1	170	3.1
SCOTT COUNTY	6,614	16.7	4,795	12.1	3,052	7.7	1,347	3.4	396	1.0
SHANNON COUNTY	1,557	19.7	1,119	14.2	692	8.8	326	4.1	101	1.3
SHELBY COUNTY	2,191	28.0	1,762	22.5	980	12.5	585	7.5	197	2.5
STODDARD COUNTY	6,218	21.4	4,650	16.0	2,816	9.7	1,395	4.8	439	1.5
STONE COUNTY	4,248	27.3	3,059	19.6	2,194	14.1	740	4.7	125	0.8
SULLIVAN COUNTY	2,123	28.6	1,650	22.2	950	12.8	537	7.2	163	2.2
TANEY COUNTY	5,966	29.1	4,409	21.5	2,961	14.5	1,180	5.8	268	1.3
TEXAS COUNTY	4,539	21.5	3,383	16.1	2,066	9.8	1,034	4.9	283	1.3
VERNON COUNTY	4,490	22.7	3,377	17.1	1,871	9.4	1,124	5.7	382	1.9
WARREN COUNTY	2,995	20.1	2,270	15.2	1,408	9.4	678	4.6	184	1.2
WASHINGTON COUNTY	2,856	15.9	2,074	11.5	1,344	7.5	593	3.3	137	0.8
WAYNE COUNTY	2,917	25.9	2,201	19.5	1,414	12.5	606	5.4	181	1.6
WEBSTER COUNTY	3,578	17.5	2,743	13.4	1,642	8.0	829	4.1	272	1.3
WORTH COUNTY	935	31.1	763	25.4	405	13.5	272	9.0	86	2.9
WRIGHT COUNTY	3,567	22.0	2,721	16.8	1,605	9.9	875	5.4	241	1.5
ST. LOUIS CITY	103,443	22.8	79,920	17.6	45,277	10.0	27,134	6.0	7,509	1.7
MONTANA	119,240	15.2	84,559	10.7	51,528	6.5	24,194	3.1	8,837	1.1
BEAVERHEAD COUNTY	1,343	16.4	988	12.1	621	7.6	297	3.6	70	0.9
BIG HORN COUNTY	1,299	11.7	901	8.1	593	5.3	239	2.2	69	0.6
BLAINE COUNTY	1,143	16.3	846	12.1	517	7.4	232	3.3	97	1.4
BROADWATER COUNTY	578	17.7	408	12.5	242	7.4	121	3.7	45	1.4
CARBON COUNTY	1,907	23.5	1,435	17.7	871	10.8	407	5.0	157	1.9
CARTER COUNTY	368	20.5	273	15.2	148	8.2	95	5.3	30	1.7
CASCADE COUNTY	11,310	14.0	7,988	9.9	4,783	5.9	2,393	3.0	812	1.0
CHOUTEAU COUNTY	1,164	19.1	796	13.1	483	7.9	215	3.5	98	1.6
CUSTER COUNTY	2,403	18.3	1,734	13.2	944	7.2	550	4.2	240	1.8
DANIELS COUNTY	631	22.3	454	16.0	247	8.7	135	4.8	72	2.5
DAWSON COUNTY	1,625	13.8	1,143	9.7	716	6.1	340	2.9	87	0.7
DEER LODGE COUNTY	2,564	20.5	1,787	14.3	1,152	9.2	499	4.0	136	1.1
FALLON COUNTY	567	15.1	395	10.5	262	7.0	93	2.5	40	1.1
FERGUS COUNTY	2,819	21.6	2,114	16.2	1,182	9.0	653	5.0	279	2.1
FLATHEAD COUNTY	7,653	14.7	5,376	10.3	3,261	6.3	1,595	3.1	520	1.0
GALLATIN COUNTY	4,613	10.8	3,234	7.5	1,855	4.3	1,000	2.3	379	0.9
GARFIELD COUNTY	281	17.0	180	10.9	116	7.0	39	2.4	25	1.5
GLACIER COUNTY	1,399	13.2	977	9.2	629	5.9	277	2.6	71	0.7
GOLDEN VALLEY COUNTY	208	20.3	147	14.3	87	8.5	44	4.3	16	1.6
GRANITE COUNTY	548	20.3	386	14.3	237	8.8	101	3.7	48	1.8
HILL COUNTY	2,452	13.6	1,678	9.3	962	5.3	490	2.7	226	1.3
JEFFERSON COUNTY	913	13.0	619	8.8	404	5.7	164	2.3	51	0.7
JUDITH BASIN COUNTY	538	20.3	394	14.9	256	9.7	109	4.1	29	1.1
LAKE COUNTY	3,579	18.8	2,622	13.8	1,670	8.8	727	3.8	225	1.2
LEWIS AND CLARK COUNTY	5,896	13.7	4,124	9.6	2,521	5.9	1,149	2.7	454	1.1
LIBERTY COUNTY	378	16.2	262	11.2	164	7.0	62	2.7	36	1.5
LINCOLN COUNTY	2,167	12.2	1,420	8.0	973	5.5	333	1.9	114	0.6
MCCONE COUNTY	426	15.8	278	10.3	188	7.0	63	2.3	27	1.0
MADISON COUNTY	1,185	21.8	893	16.4	543	10.0	256	4.7	94	1.7
MEAGHER COUNTY	389	18.1	278	12.9	186	8.6	71	3.3	21	1.0
MINERAL COUNTY	497	13.5	334	9.1	224	6.1	85	2.3	25	0.7
MISSOULA COUNTY	8,655	11.4	6,134	8.1	3,687	4.9	1,765	2.3	682	0.9
MUSSELSHELL COUNTY	947	21.4	696	15.7	430	9.7	207	4.7	59	1.3
PARK COUNTY	2,493	19.7	1,837	14.5	1,079	8.5	575	4.5	183	1.4
PETROLEUM COUNTY	103	15.7	66	10.1	58	8.9	6	0.9	2	0.3
PHILLIPS COUNTY	988	18.4	734	13.7	416	7.8	209	3.9	109	2.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
PONDERA COUNTY	1,160	17.2	851	12.6	485	7.2	258	3.8	108	1.6
POWDER RIVER COUNTY	378	15.0	254	10.1	149	5.9	76	3.0	29	1.2
POWELL COUNTY	1,133	16.3	793	11.4	477	6.9	213	3.1	103	1.5
PRAIRIE COUNTY	449	24.5	328	17.9	217	11.8	82	4.5	29	1.6
RAVALLI COUNTY	4,159	18.5	2,989	13.3	1,826	8.1	855	3.8	308	1.4
RICHLAND COUNTY	1,736	14.2	1,249	10.2	777	6.3	327	2.7	145	1.2
ROOSEVELT COUNTY	1,522	14.5	1,060	10.1	629	6.0	284	2.7	147	1.4
ROSEBUD COUNTY	893	9.0	586	5.9	352	3.6	152	1.5	82	0.8
SANDERS COUNTY	1,617	18.6	1,183	13.6	724	8.3	363	4.2	96	1.1
SHERIDAN COUNTY	1,164	21.5	836	15.4	497	9.2	215	4.0	124	2.3
SILVER BOW COUNTY	7,922	20.8	5,686	14.9	3,548	9.3	1,656	4.3	482	1.3
STILLWATER COUNTY	1,192	21.3	889	15.9	543	9.7	251	4.5	95	1.7
SWEET GRASS COUNTY	790	24.6	608	18.9	353	11.0	175	5.4	80	2.5
TETON COUNTY	1,312	20.2	944	14.5	549	8.5	275	4.2	120	1.8
TOOLE COUNTY	963	17.3	656	11.8	403	7.2	185	3.3	68	1.2
TREASURE COUNTY	178	18.1	129	13.1	79	8.1	34	3.5	16	1.6
VALLEY COUNTY	1,630	15.9	1,159	11.3	713	7.0	322	3.1	124	1.2
WHEATLAND COUNTY	528	22.4	365	15.5	209	8.9	112	4.7	44	1.9
WIBAUX COUNTY	275	18.6	201	13.6	111	7.5	56	3.8	34	2.3
YELLOWSTONE COUNTY	14,177	13.1	9,841	9.1	6,168	5.7	2,700	2.5	973	0.9
YELLOWSTONE NATIONAL PARK	33	12.0	21	7.6	12	4.4	7	2.5	2	0.7
NEBRASKA	273,212	17.4	205,684	13.1	114,021	7.3	67,919	4.3	23,744	1.5
ADAMS COUNTY	6,239	20.4	4,790	15.6	2,468	8.1	1,673	5.5	649	2.1
ANTELOPE COUNTY	2,027	23.4	1,587	18.3	842	9.7	579	6.7	166	1.9
ARTHUR COUNTY	102	19.9	76	14.8	50	9.7	16	3.1	10	1.9
BANNER COUNTY	163	17.8	101	11.0	74	8.1	26	2.8	1	0.1
BLAINE COUNTY	174	20.1	140	16.1	80	9.2	51	5.9	9	1.0
BOONE COUNTY	1,721	23.3	1,343	18.2	734	9.9	452	6.1	157	2.1
BOX BUTTE COUNTY	2,241	16.4	1,717	12.5	878	6.4	628	4.6	211	1.5
BOYD COUNTY	957	28.7	737	22.1	389	11.7	282	8.5	66	2.0
BROWN COUNTY	1,023	23.4	796	18.2	424	9.7	277	6.3	95	2.2
BUFFALO COUNTY	5,430	15.6	4,162	12.0	2,251	6.5	1,417	4.1	494	1.4
BURT COUNTY	2,358	26.8	1,849	21.0	973	11.0	641	7.3	235	2.7
BUTLER COUNTY	2,332	25.0	1,792	19.2	963	10.3	620	6.6	209	2.2
CASS COUNTY	3,520	17.3	2,601	12.8	1,489	7.3	793	3.9	319	1.6
CEDAR COUNTY	2,543	22.4	1,980	17.4	1,023	9.0	723	6.4	234	2.1
CHASE COUNTY	1,004	21.1	759	16.0	395	8.3	268	5.6	96	2.0
CHERRY COUNTY	1,323	19.6	997	14.8	554	8.2	326	4.8	117	1.7
CHEYENNE COUNTY	2,075	20.6	1,567	15.6	921	9.2	470	4.7	176	1.8
CLAY COUNTY	1,805	22.3	1,437	17.7	753	9.3	470	5.8	214	2.6
COLFAX COUNTY	2,536	25.6	2,030	20.5	1,099	11.1	692	7.0	239	2.4
CUMING COUNTY	2,589	22.2	1,986	17.0	1,079	9.3	690	5.9	217	1.9
CUSTER COUNTY	3,502	25.2	2,725	19.6	1,513	10.9	884	6.4	328	2.4
DAKOTA COUNTY	2,349	14.2	1,712	10.3	978	5.9	561	3.4	173	1.0
DAWES COUNTY	1,848	19.2	1,404	14.6	749	7.8	472	4.9	183	1.9
DAWSON COUNTY	4,182	18.8	3,116	14.0	1,718	7.7	998	4.5	400	1.8
DEUEL COUNTY	698	28.4	530	21.5	292	11.9	169	6.9	69	2.8
DIXON COUNTY	1,675	23.5	1,327	18.6	712	10.0	453	6.3	162	2.3
DODGE COUNTY	7,018	19.6	5,418	15.1	2,906	8.1	1,846	5.1	666	1.9
DOUGLAS COUNTY	57,134	14.4	41,483	10.4	24,055	6.1	13,263	3.3	4,165	1.0
DUNDY COUNTY	797	27.8	593	20.7	336	11.7	188	6.6	69	2.4
FILLMORE COUNTY	1,963	24.8	1,573	19.9	792	10.0	525	6.6	256	3.2
FRANKLIN COUNTY	1,331	30.4	1,054	24.1	559	12.8	366	8.4	129	2.9
FRONTIER COUNTY	765	21.0	620	17.0	327	9.0	224	6.1	69	1.9
FURNAS COUNTY	2,011	31.0	1,627	25.1	808	12.5	578	8.9	241	3.7
GAGE COUNTY	5,744	23.5	4,432	18.1	2,465	10.1	1,450	5.9	517	2.1
GARDEN COUNTY	787	28.1	619	22.1	320	11.4	220	7.9	79	2.8

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
GARFIELD COUNTY	673	28.5	533	22.6	286	12.1	208	8.8	39	1.7
GOSPER COUNTY	472	22.1	347	16.2	188	8.8	108	5.0	51	2.4
GRANT COUNTY	151	17.2	119	13.6	72	8.2	40	4.6	7	0.8
GREELEY COUNTY	865	25.0	673	19.4	366	10.6	223	6.4	84	2.4
HALL COUNTY	7,917	16.6	5,964	12.5	3,354	7.0	1,910	4.0	700	1.5
HAMILTON COUNTY	1,708	18.4	1,299	14.0	668	7.2	454	4.9	177	1.9
HARLAN COUNTY	1,197	27.9	920	21.4	486	11.3	336	7.8	98	2.3
HAYES COUNTY	265	19.5	178	13.1	108	8.0	63	4.6	7	0.5
HITCHCOCK COUNTY	983	24.1	752	18.4	395	9.7	271	6.6	86	2.1
HOLT COUNTY	2,773	20.5	2,083	15.4	1,132	8.4	701	5.2	250	1.8
HOOKER COUNTY	247	24.9	190	19.2	105	10.6	54	5.5	31	3.1
HOWARD COUNTY	1,479	21.8	1,123	16.6	611	9.0	383	5.7	129	1.9
JEFFERSON COUNTY	2,631	26.8	2,025	20.6	1,114	11.3	675	6.9	236	2.4
JOHNSON COUNTY	1,448	27.4	1,152	21.8	620	11.7	390	7.4	142	2.7
KEARNEY COUNTY	1,532	21.7	1,179	16.7	622	8.8	393	5.6	164	2.3
KEITH COUNTY	1,731	18.5	1,275	13.6	745	8.0	412	4.4	118	1.3
KEYA PAHA COUNTY	281	21.6	205	15.8	134	10.3	52	4.0	19	1.5
KIMBALL COUNTY	914	18.7	677	13.9	386	7.9	203	4.2	88	1.8
KNOX COUNTY	2,817	24.6	2,196	19.2	1,143	10.0	790	6.9	263	2.3
LANCASTER COUNTY	26,614	13.8	19,572	10.1	10,950	5.7	6,410	3.3	2,212	1.1
LINCOLN COUNTY	5,839	16.0	4,342	11.9	2,583	7.1	1,322	3.6	437	1.2
LOGAN COUNTY	191	19.4	145	14.8	83	8.4	49	5.0	13	1.3
LOUP COUNTY	196	22.8	144	16.8	90	10.5	42	4.9	12	1.4
MCPHERSON COUNTY	147	24.8	105	17.7	73	12.3	29	4.9	3	0.5
MADISON COUNTY	5,927	18.9	4,580	14.6	2,441	7.8	1,587	5.1	552	1.8
MERRICK COUNTY	1,816	20.3	1,406	15.7	756	8.5	494	5.5	156	1.7
MORRILL COUNTY	1,351	22.2	1,037	17.0	584	9.6	341	5.6	112	1.8
NANCE COUNTY	1,132	23.9	886	18.7	471	9.9	331	7.0	84	1.8
NEMAHA COUNTY	1,999	23.9	1,539	18.4	857	10.2	484	5.8	198	2.4
NUCKOLLS COUNTY	1,730	25.7	1,335	19.8	690	10.3	468	7.0	177	2.6
OTOE COUNTY	3,782	24.9	2,943	19.4	1,534	10.1	998	6.6	411	2.7
PAWNEE COUNTY	1,261	32.0	977	24.8	499	12.7	352	8.9	126	3.2
PERKINS COUNTY	854	23.5	638	17.5	344	9.5	210	5.8	84	2.3
PHELPS COUNTY	2,217	22.7	1,744	17.9	876	9.0	577	5.9	291	3.0
PIERCE COUNTY	1,926	22.7	1,452	17.1	815	9.6	479	5.6	158	1.9
PLATTE COUNTY	4,684	16.2	3,529	12.2	2,026	7.0	1,140	4.0	363	1.3
POLK COUNTY	1,582	25.0	1,265	20.0	670	10.6	438	6.9	157	2.5
RED WILLOW COUNTY	2,561	20.3	1,954	15.5	1,087	8.6	654	5.2	213	1.7
RICHARDSON COUNTY	3,275	28.5	2,536	22.4	1,287	11.4	884	7.8	365	3.2
ROCK COUNTY	504	21.1	396	16.6	214	9.0	143	6.0	39	1.6
SALINE COUNTY	3,356	25.6	2,612	19.9	1,280	9.7	946	7.2	386	2.9
SARPY COUNTY	4,502	5.2	2,909	3.4	1,803	2.1	804	0.9	302	0.4
SAUNDERS COUNTY	3,844	20.5	2,949	15.8	1,611	8.6	991	5.3	347	1.9
SCOTTS BLUFF COUNTY	6,756	17.6	4,989	13.0	3,038	7.9	1,480	3.9	471	1.2
SEWARD COUNTY	2,882	18.3	2,215	14.0	1,205	7.6	741	4.7	269	1.7
SHERIDAN COUNTY	1,732	23.0	1,290	17.1	658	8.7	433	5.7	199	2.6
SHERMAN COUNTY	1,132	26.8	875	20.7	503	11.9	260	6.2	112	2.7
SIOUX COUNTY	356	19.3	254	13.8	172	9.3	73	4.0	9	0.5
STANTON COUNTY	1,060	16.2	799	12.2	463	7.1	232	3.5	104	1.6
THAYER COUNTY	2,137	28.2	1,665	22.0	886	11.7	577	7.6	202	2.7
THOMAS COUNTY	169	17.4	119	12.2	72	7.4	41	4.2	6	0.6
THURSTON COUNTY	1,269	17.7	965	13.4	492	6.8	359	5.0	114	1.6
VALLEY COUNTY	1,490	26.5	1,158	20.6	639	11.3	377	6.7	142	2.5
WASHINGTON COUNTY	2,572	16.6	1,916	12.4	1,052	6.8	633	4.1	231	1.5
WAYNE COUNTY	1,724	17.5	1,366	13.9	768	7.8	470	4.8	128	1.3
WEBSTER COUNTY	1,461	30.1	1,131	23.3	578	11.9	375	7.7	178	3.7
WHEELER COUNTY	189	17.8	136	12.8	92	8.7	38	3.6	6	0.6

AREA NAME	POPULATION 60+ #	%	POPULATION 65+ #	%	POP 65-74 #	%	POP 75-84 #	%	POP 85+ #	%
YORK COUNTY	2,943	19.9	2,241	15.1	1,275	8.6	700	4.7	266	1.8
NEVADA	101,339	12.7	65,756	8.2	45,998	5.7	16,118	2.0	3,640	0.5
CHURCHILL COUNTY	2,424	17.4	1,727	12.4	1,084	7.8	504	3.6	139	1.0
CLARK COUNTY	54,690	11.8	35,112	7.6	25,186	5.4	8,313	1.8	1,613	0.3
DOUGLAS COUNTY	2,592	13.3	1,550	8.0	1,123	5.8	359	1.8	68	0.4
ELKO COUNTY	2,278	13.2	1,543	8.9	1,025	5.9	415	2.4	103	0.6
ESMERALDA COUNTY	137	17.6	86	11.1	59	7.6	23	3.0	4	0.5
EUREKA COUNTY	138	11.5	80	6.7	45	3.8	26	2.2	9	0.8
HUMBOLDT COUNTY	1,108	11.7	697	7.4	474	5.0	182	1.9	41	0.4
LANDER COUNTY	337	8.3	217	5.3	163	4.0	39	1.0	15	0.4
LINCOLN COUNTY	651	17.4	478	12.8	341	9.1	109	2.9	28	0.8
LYON COUNTY	2,359	17.4	1,559	11.5	1,083	8.0	376	2.8	100	0.7
MINERAL COUNTY	1,028	16.5	669	10.8	453	7.3	175	2.8	41	0.7
NYE COUNTY	1,350	14.9	818	9.0	601	6.6	174	1.9	43	0.5
PERSHING COUNTY	620	18.2	390	11.4	260	7.6	104	3.1	26	0.8
STOREY COUNTY	206	13.7	131	8.7	109	7.3	16	1.1	6	0.4
WASHOE COUNTY	25,082	13.0	16,402	8.5	11,044	5.7	4,252	2.2	1,106	0.6
WHITE PINE COUNTY	1,404	17.2	984	12.0	618	7.6	297	3.6	69	0.8
CARSON CITY	4,935	15.4	3,313	10.3	2,330	7.3	754	2.4	229	0.7
NEW HAMPSHIRE	142,644	15.5	102,967	11.2	61,788	6.7	31,529	3.4	9,650	1.0
BELKNAP COUNTY	7,874	18.4	5,671	13.2	3,430	8.0	1,729	4.0	512	1.2
CARROLL COUNTY	6,172	22.1	4,539	16.3	2,886	10.3	1,287	4.6	366	1.3
CHESHIRE COUNTY	10,662	17.2	7,664	12.3	4,657	7.5	2,290	3.7	717	1.2
COOS COUNTY	6,832	19.4	4,983	14.2	2,976	8.5	1,533	4.4	474	1.3
GRAFTON COUNTY	10,972	16.7	8,133	12.4	4,906	7.5	2,478	3.8	749	1.1
HILLSBOROUGH COUNTY	39,542	14.3	28,214	10.2	16,763	6.1	8,730	3.2	2,716	1.0
MERRIMACK COUNTY	16,650	16.9	12,371	12.6	7,096	7.2	3,964	4.0	1,311	1.3
ROCKINGHAM COUNTY	25,124	13.2	17,809	9.4	10,986	5.8	5,223	2.7	1,600	0.8
STRAFFORD COUNTY	12,203	14.3	8,771	10.3	5,273	6.2	2,742	3.2	756	0.9
SULLIVAN COUNTY	6,613	18.3	4,812	13.3	2,810	7.8	1,553	4.3	449	1.2
NEW JERSEY	1,227,431	16.7	859,771	11.7	530,707	7.2	256,833	3.5	72,231	1.0
ATLANTIC COUNTY	41,141	21.2	30,787	15.9	17,881	9.2	10,026	5.2	2,880	1.5
BERGEN COUNTY	154,111	18.2	105,276	12.5	65,032	7.7	31,314	3.7	8,930	1.1
BURLINGTON COUNTY	42,686	11.8	28,682	7.9	17,684	4.9	8,253	2.3	2,745	0.8
CAMDEN COUNTY	71,982	15.3	49,232	10.4	30,975	6.6	14,427	3.1	3,830	0.8
CAPE MAY COUNTY	22,379	27.2	16,733	20.3	10,454	12.7	5,028	6.1	1,251	1.5
CUMBERLAND COUNTY	21,800	16.4	15,516	11.7	9,714	7.3	4,522	3.4	1,280	1.0
ESSEX COUNTY	139,901	16.4	98,761	11.6	60,004	7.1	30,354	3.6	8,403	1.0
GLOUCESTER COUNTY	26,329	13.2	17,723	8.9	11,173	5.6	4,969	2.5	1,581	0.8
HUDSON COUNTY	99,354	17.8	69,932	12.6	43,474	7.8	20,970	3.8	5,488	1.0
HUNTERDON COUNTY	11,547	13.2	8,104	9.3	4,855	5.6	2,521	2.9	728	0.8
MERCER COUNTY	50,592	16.4	35,200	11.4	21,650	7.0	10,434	3.4	3,116	1.0
MIDDLESEX COUNTY	81,338	13.6	52,732	8.8	34,250	5.7	14,455	2.4	4,027	0.7
MONMOUTH COUNTY	82,693	16.4	59,536	11.8	35,162	7.0	18,724	3.7	5,650	1.1
MORRIS COUNTY	51,946	12.7	35,796	8.8	21,163	5.2	10,901	2.7	3,732	0.9
OCEAN COUNTY	92,927	26.9	71,809	20.8	46,850	13.5	21,120	6.1	3,839	1.1
PASSAIC COUNTY	75,109	16.8	53,141	11.9	32,106	7.2	16,138	3.6	4,897	1.1
SALEM COUNTY	10,906	16.9	7,538	11.7	4,800	7.4	2,057	3.2	681	1.1
SOMERSET COUNTY	27,854	13.7	18,282	9.0	11,095	5.5	5,353	2.6	1,834	0.9
SUSSEX COUNTY	14,210	12.2	10,135	8.7	6,123	5.3	2,995	2.6	1,017	0.9
UNION COUNTY	94,309	18.7	64,667	12.8	39,998	7.9	19,248	3.8	5,421	1.1
WARREN COUNTY	14,317	17.0	10,189	12.1	6,264	7.4	3,024	3.6	901	1.1
NEW MEXICO	164,661	12.6	115,906	8.9	74,732	5.7	32,391	2.5	8,783	0.7
BERNALILLO COUNTY	49,487	11.8	34,000	8.1	22,134	5.3	9,340	2.2	2,526	0.6
CATRON COUNTY	495	18.2	368	13.5	244	9.0	109	4.0	15	0.6
CHAVES COUNTY	9,809	19.2	7,213	14.1	4,716	9.2	1,969	3.9	528	1.0
COLFAX COUNTY	2,411	17.6	1,780	13.0	1,073	7.9	540	4.0	167	1.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
CURRY COUNTY	5,514	13.1	4,041	9.6	2,422	5.8	1,280	3.0	339	0.8
DE BACA COUNTY	669	27.3	516	21.0	285	11.6	169	6.9	62	2.5
DONA ANA COUNTY	10,007	10.4	6,943	7.2	4,442	4.6	2,000	2.1	501	0.5
EDDY COUNTY	8,230	17.2	5,997	12.5	3,868	8.1	1,732	3.6	397	0.8
GRANT COUNTY	3,839	14.7	2,753	10.5	1,735	6.6	772	2.9	246	0.9
GUADALUPE COUNTY	724	16.1	547	12.2	356	7.9	151	3.4	40	0.9
HARDING COUNTY	259	23.8	191	17.5	125	11.5	44	4.0	22	2.0
HIDALGO COUNTY	791	13.1	561	9.3	338	5.6	174	2.9	49	0.8
LEA COUNTY	6,597	11.8	4,488	8.0	2,999	5.4	1,201	2.1	288	0.5
LINCOLN COUNTY	1,959	17.8	1,338	12.2	946	8.6	309	2.8	83	0.8
LOS ALAMOS COUNTY	1,393	7.9	722	4.1	503	2.9	167	0.9	52	0.3
LUNA COUNTY	3,655	23.5	2,625	16.8	1,803	11.6	676	4.3	146	0.9
MCKINLEY COUNTY	4,068	7.2	2,778	4.9	1,782	3.2	775	1.4	221	0.4
MORA COUNTY	798	19.0	621	14.8	360	8.6	205	4.9	56	1.3
OTERO COUNTY	4,279	9.6	2,956	6.6	1,979	4.4	766	1.7	211	0.5
QUAY COUNTY	2,236	21.1	1,656	15.7	1,031	9.7	491	4.6	134	1.3
RIO ARRIBA COUNTY	3,360	11.5	2,413	8.2	1,462	5.0	758	2.6	193	0.7
ROOSEVELT COUNTY	2,714	17.3	2,022	12.9	1,221	7.8	633	4.0	168	1.1
SANDOVAL COUNTY	5,011	14.4	3,421	9.8	2,377	6.8	844	2.4	200	0.6
SAN JUAN COUNTY	6,996	8.6	4,759	5.8	3,175	3.9	1,219	1.5	365	0.4
SAN MIGUEL COUNTY	3,543	15.6	2,647	11.6	1,544	6.8	825	3.6	278	1.2
SANTA FE COUNTY	9,536	12.7	6,803	9.0	4,256	5.6	1,967	2.6	580	0.8
SIERRA COUNTY	3,188	37.7	2,494	29.5	1,627	19.2	699	8.3	168	2.0
SOCORRO COUNTY	1,578	12.6	1,112	8.8	734	5.8	293	2.3	85	0.7
TAOS COUNTY	2,596	13.3	1,894	9.7	1,169	6.0	536	2.8	189	1.0
TORRANCE COUNTY	1,289	17.2	898	12.0	570	7.6	266	3.6	62	0.8
UNION COUNTY	1,083	22.9	813	17.2	460	9.7	258	5.5	95	2.0
VALENCIA COUNTY	6,542	10.7	4,536	7.4	2,995	4.9	1,223	2.0	317	0.5
NEW YORK	3,001,774	17.1	2,160,767	12.3	1,292,428	7.4	675,356	3.8	192,983	1.1
ALBANY COUNTY	52,881	18.5	38,594	13.5	22,588	7.9	12,283	4.3	3,723	1.3
ALLEGANY COUNTY	8,211	15.9	5,979	11.6	3,562	6.9	1,810	3.5	607	1.2
BRONX COUNTY	202,332	17.3	151,298	12.9	87,224	7.5	49,848	4.3	14,226	1.2
BROOME COUNTY	38,554	18.0	27,645	12.9	16,162	7.6	8,725	4.1	2,758	1.3
CATTARAUGUS COUNTY	14,868	17.3	10,784	12.6	6,303	7.4	3,436	4.0	1,045	1.2
CAYUGA COUNTY	14,413	18.0	10,447	13.1	6,158	7.7	3,124	3.9	1,165	1.5
CHAUTAUQUA COUNTY	28,497	19.4	20,879	14.2	12,120	8.2	6,608	4.5	2,151	1.5
CHEMUNG COUNTY	17,517	17.9	12,500	12.8	7,276	7.5	3,942	4.0	1,282	1.3
CHENANGO COUNTY	8,528	17.3	6,162	12.5	3,610	7.3	1,859	3.8	693	1.4
CLINTON COUNTY	9,517	11.8	6,905	8.6	4,203	5.2	2,128	2.6	574	0.7
COLUMBIA COUNTY	12,662	21.3	9,421	15.8	5,578	9.4	2,928	4.9	915	1.5
CORTLAND COUNTY	7,383	15.1	5,429	11.1	3,149	6.5	1,699	3.5	581	1.2
DELAWARE COUNTY	9,319	19.9	6,867	14.7	4,025	8.6	2,099	4.5	743	1.6
DUTCHESS COUNTY	37,316	15.2	27,146	11.1	16,338	6.7	8,287	3.4	2,521	1.0
ERIE COUNTY	179,890	17.7	126,176	12.4	76,905	7.6	38,243	3.8	11,028	1.1
ESSEX COUNTY	7,178	19.8	5,269	14.6	3,147	8.7	1,599	4.4	523	1.4
FRANKLIN COUNTY	7,792	17.3	5,731	12.8	3,369	7.5	1,826	4.1	536	1.2
FULTON COUNTY	11,358	20.6	8,238	14.9	4,990	9.0	2,445	4.4	803	1.5
GENESEE COUNTY	9,815	16.5	7,031	11.8	4,128	6.9	2,184	3.7	719	1.2
GREENE COUNTY	9,199	22.5	6,945	17.0	4,106	10.0	2,152	5.3	687	1.7
HAMILTON COUNTY	1,202	23.9	837	16.6	529	10.5	262	5.2	46	0.9
HERKIMER COUNTY	13,164	19.7	9,265	13.9	5,561	8.3	2,794	4.2	910	1.4
JEFFERSON COUNTY	15,678	17.8	11,518	13.1	6,665	7.6	3,637	4.1	1,216	1.4
KINGS COUNTY	385,008	17.3	279,544	12.5	172,749	7.7	86,188	3.9	20,607	0.9
LEWIS COUNTY	3,997	16.0	2,913	11.6	1,658	6.6	932	3.7	323	1.3
LIVINGSTON COUNTY	8,282	14.5	5,998	10.5	3,621	6.4	1,783	3.1	594	1.0
MADISON COUNTY	9,391	14.4	6,590	10.1	4,009	6.2	1,927	3.0	654	1.0
MONROE COUNTY	108,466	15.4	76,976	11.0	43,916	6.3	24,535	3.5	8,525	1.2

POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
#	%	#	%	#	%	#	%	#	%
12,463	23.3	9,090	17.0	5,435	10.2	2,677	5.0	978	1.8
214,039	16.2	140,396	10.6	85,701	6.5	41,691	3.2	13,004	1.0
271,073	19.0	204,437	14.3	118,832	8.3	68,720	4.8	16,885	1.2
39,195	17.2	27,127	11.9	16,687	7.3	7,872	3.5	2,568	1.1
47,635	18.8	33,984	13.4	20,010	7.9	10,142	4.0	3,832	1.5
71,953	15.5	50,848	11.0	29,899	6.4	15,978	3.4	4,971	1.1
14,357	16.1	10,313	11.6	6,138	6.9	3,107	3.5	1,068	1.2
39,009	15.0	28,184	10.9	17,202	6.6	8,510	3.3	2,472	1.0
6,517	16.9	4,649	12.1	2,666	6.9	1,438	3.7	545	1.4
15,860	13.9	11,120	9.8	6,761	5.9	3,293	2.9	1,066	0.9
11,330	19.2	8,487	14.4	4,887	8.3	2,642	4.5	958	1.6
10,019	13.0	7,330	9.5	4,559	5.9	2,223	2.9	548	0.7
388,449	20.5	281,328	14.9	170,253	9.0	88,747	4.7	22,328	1.2
26,211	17.2	18,949	12.5	11,164	7.3	6,037	4.0	1,748	1.2
50,103	14.2	35,125	10.0	21,461	6.1	10,378	2.9	3,286	0.9
30,715	11.8	22,082	8.5	12,719	4.9	7,158	2.8	2,205	0.8
16,890	14.8	12,252	10.7	7,306	6.4	3,792	3.3	1,154	1.0
20,045	13.0	14,058	9.1	8,661	5.6	4,145	2.7	1,252	0.8
30,236	20.2	21,632	14.4	12,839	8.6	6,641	4.4	2,152	1.4
5,239	17.6	3,872	13.0	2,234	7.5	1,234	4.2	404	1.4
3,070	17.4	2,196	12.4	1,282	7.2	651	3.7	263	1.5
6,115	18.1	4,424	13.1	2,598	7.7	1,340	4.0	486	1.4
17,737	17.9	12,670	12.8	7,393	7.5	3,962	4.0	1,315	1.3
162,864	12.7	115,828	9.0	69,769	5.4	36,070	2.8	9,989	0.8
13,395	20.6	9,835	15.1	6,264	9.6	2,825	4.3	746	1.1
6,469	13.0	4,611	9.3	2,791	5.6	1,378	2.8	442	0.9
10,029	11.5	7,252	8.3	4,275	4.9	2,174	2.5	803	0.9
27,555	17.4	20,460	12.9	12,310	7.8	6,317	4.0	1,833	1.2
9,724	17.7	7,222	13.2	4,273	7.8	2,272	4.1	677	1.2
9,363	17.1	6,825	12.5	4,001	7.3	2,129	3.9	695	1.3
12,706	15.0	9,126	10.8	5,582	6.6	2,640	3.1	904	1.1
158,371	18.3	114,159	13.2	68,329	7.9	35,386	4.1	10,444	1.2
6,280	15.7	4,543	11.4	2,643	6.6	1,390	3.5	510	1.3
4,340	20.2	3,266	15.2	1,855	8.6	1,114	5.2	297	1.4
858,313	14.6	603,181	10.3	387,587	6.6	170,391	2.9	45,203	0.8
16,608	16.7	11,437	11.5	7,547	7.6	3,081	3.1	809	0.8
3,255	13.0	2,252	9.0	1,408	5.6	651	2.6	193	0.8
1,948	20.3	1,438	15.0	846	8.8	474	4.9	118	1.2
4,635	18.1	3,330	13.0	2,042	8.0	965	3.8	323	1.3
4,336	19.4	3,233	14.5	1,940	8.7	1,017	4.6	276	1.2
2,278	15.8	1,610	11.2	1,050	7.3	459	3.2	101	0.7
7,232	17.9	5,176	12.8	3,412	8.5	1,405	3.5	359	0.9
3,773	17.9	2,699	12.8	1,794	8.5	699	3.3	206	1.0
4,840	15.9	3,315	10.9	2,246	7.4	853	2.8	216	0.7
5,692	15.9	3,847	10.8	2,674	7.5	921	2.6	252	0.7
30,220	18.8	22,096	13.7	13,255	8.2	6,781	4.2	2,060	1.3
10,491	14.5	7,194	9.9	4,741	6.5	1,969	2.7	484	0.7
14,411	16.8	10,105	11.8	6,681	7.8	2,746	3.2	678	0.8
9,150	13.5	6,369	9.4	4,206	6.2	1,747	2.6	416	0.6
986	16.9	693	11.9	433	7.4	220	3.8	40	0.7
6,830	16.6	4,758	11.6	3,126	7.6	1,292	3.1	340	0.8
3,044	14.7	2,113	10.2	1,344	6.5	598	2.9	171	0.8
14,710	14.0	10,117	9.6	6,686	6.4	2,692	2.6	739	0.7
5,412	16.2	3,801	11.4	2,362	7.1	1,104	3.3	335	1.0
3,845	20.3	2,835	15.0	1,744	9.2	819	4.3	272	1.4
2,435	19.4	1,782	14.2	1,103	8.8	528	4.2	151	1.2
1,525	23.0	1,094	16.5	684	10.3	335	5.1	75	1.1

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
CLEVELAND COUNTY	12,976	15.6	9,097	10.9	5,803	7.0	2,591	3.1	703	0.8
COLUMBUS COUNTY	7,952	15.6	5,553	10.9	3,710	7.3	1,452	2.8	391	0.8
CRAVEN COUNTY	7,978	11.2	5,450	7.7	3,638	5.1	1,433	2.0	379	0.5
CUMBERLAND COUNTY	17,065	6.9	11,219	4.5	7,664	3.1	2,818	1.1	737	0.3
CURRITUCK COUNTY	1,883	17.0	1,303	11.8	879	7.9	340	3.1	84	0.8
DARE COUNTY	2,587	19.3	1,690	12.6	1,174	8.8	415	3.1	101	0.8
DAVIDSON COUNTY	16,145	14.3	10,986	9.7	7,220	6.4	2,987	2.6	779	0.7
DAVIE COUNTY	3,538	14.4	2,510	10.2	1,573	6.4	753	3.1	184	0.7
DUPLIN COUNTY	6,799	16.6	4,761	11.6	3,207	7.8	1,204	2.9	350	0.9
DURHAM COUNTY	21,841	14.3	15,767	10.3	9,862	6.5	4,664	3.1	1,241	0.8
EDGECOMBE COUNTY	8,316	14.9	5,844	10.4	3,729	6.7	1,698	3.0	417	0.7
FORSYTH COUNTY	35,295	14.5	25,051	10.3	15,485	6.4	7,593	3.1	1,973	0.8
FRANKLIN COUNTY	5,415	18.0	3,946	13.1	2,460	8.2	1,161	3.9	325	1.1
GASTON COUNTY	23,483	14.4	16,457	10.1	10,956	6.7	4,508	2.8	993	0.6
GATES COUNTY	1,698	19.1	1,218	13.7	767	8.6	355	4.0	96	1.1
GRAHAM COUNTY	1,278	17.7	918	12.7	571	7.9	276	3.8	71	1.0
GRANVILLE COUNTY	5,440	16.0	3,828	11.2	2,454	7.2	1,091	3.2	283	0.8
GREENE COUNTY	2,273	14.1	1,531	9.5	1,067	6.6	378	2.3	63	0.5
GUILFORD COUNTY	45,086	14.2	31,938	10.1	19,930	6.3	9,476	3.0	2,532	0.8
HALIFAX COUNTY	9,473	17.1	6,745	12.2	4,324	7.8	1,912	3.5	509	0.9
HARNETT COUNTY	8,502	14.3	6,036	10.1	4,030	6.8	1,601	2.7	405	0.7
HAYWOOD COUNTY	8,854	19.0	6,315	13.6	3,882	8.3	1,897	4.1	536	1.2
HENDERSON COUNTY	13,794	23.5	10,359	17.7	6,454	11.0	3,054	5.2	851	1.5
HERTFORD COUNTY	3,979	17.0	2,819	12.1	1,774	7.6	810	3.5	235	1.0
HOKE COUNTY	2,332	11.4	1,597	7.8	1,032	5.1	433	2.1	132	0.6
HYDE COUNTY	1,196	20.4	886	15.1	564	9.6	249	4.2	73	1.2
IREDELL COUNTY	13,354	16.2	9,456	11.5	6,073	7.4	2,679	3.2	704	0.9
JACKSON COUNTY	3,937	15.3	2,836	11.0	1,746	6.8	833	3.2	257	1.0
JOHNSTON COUNTY	11,161	15.8	7,663	10.9	5,094	7.2	2,082	2.9	487	0.7
JONES COUNTY	1,634	16.8	1,134	11.7	779	8.0	287	3.0	68	0.7
LEE COUNTY	5,363	14.6	3,625	9.9	2,299	6.3	1,016	2.8	310	0.8
LENOIR COUNTY	9,048	15.1	6,210	10.4	4,134	6.9	1,705	2.9	371	0.6
LINCOLN COUNTY	5,917	14.0	4,090	9.7	2,676	6.3	1,099	2.6	315	0.7
MCDOWELL COUNTY	5,709	16.2	4,072	11.6	2,586	7.4	1,200	3.4	286	0.8
MACON COUNTY	4,989	24.7	3,697	18.3	2,410	11.9	1,052	5.2	235	1.2
MADISON COUNTY	3,315	19.7	2,426	14.4	1,485	8.8	749	4.5	192	1.1
MARTIN COUNTY	4,268	16.4	2,982	11.5	2,010	7.7	775	3.0	197	0.8
MECKLENBURG COUNTY	48,988	12.1	33,844	8.4	21,441	5.3	9,729	2.4	2,674	0.7
MITCHELL COUNTY	2,946	20.4	2,148	14.9	1,326	9.2	652	4.5	170	1.2
MONTGOMERY COUNTY	3,807	16.9	2,672	11.9	1,636	7.3	797	3.5	239	1.1
MOORE COUNTY	10,430	20.7	7,425	14.7	4,949	9.8	1,934	3.8	542	1.1
NASH COUNTY	10,211	15.2	7,059	10.5	4,584	6.8	2,012	3.0	463	0.7
NEW HANOVER COUNTY	15,084	14.6	10,440	10.1	6,782	6.6	2,915	2.8	743	0.7
NORTHAMPTON COUNTY	4,222	18.7	2,980	13.2	1,886	8.4	838	3.7	256	1.1
ONSLOW COUNTY	6,282	5.6	4,148	3.7	2,826	2.5	1,030	0.9	292	0.3
ORANGE COUNTY	8,109	10.5	5,783	7.5	3,553	4.6	1,752	2.3	478	0.6
PAMLICO COUNTY	1,985	19.1	1,424	13.7	897	8.6	413	4.0	114	1.1
PASQUOTANK COUNTY	4,635	16.3	3,287	11.5	2,043	7.2	970	3.4	274	1.0
PENDER COUNTY	3,819	17.2	2,659	12.0	1,750	7.9	730	3.3	179	0.8
PERQUIMANS COUNTY	2,090	22.0	1,510	15.9	966	10.2	428	4.5	116	1.2
PERSON COUNTY	4,800	16.5	3,351	11.5	2,199	7.5	910	3.1	242	0.8
PITT COUNTY	11,239	12.5	7,723	8.6	5,059	5.6	2,130	2.4	534	0.6
POLK COUNTY	3,493	26.9	2,664	20.5	1,592	12.3	857	6.6	215	1.7
RANDOLPH COUNTY	13,415	14.6	9,175	10.0	6,167	6.7	2,438	2.7	570	0.6
RICHMOND COUNTY	7,576	16.7	5,236	11.5	3,436	7.6	1,446	3.2	354	0.8
ROBESON COUNTY	13,416	13.2	9,366	9.2	6,228	6.1	2,514	2.5	624	0.6
ROCKINGHAM COUNTY	13,701	16.4	9,654	11.6	6,339	7.6	2,694	3.2	621	0.7

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
ROWAN COUNTY	18,477	18.6	13,061	13.2	8,293	8.4	3,708	3.7	1,060	1.1
RUTHERFORD COUNTY	10,006	18.6	7,234	13.4	4,571	8.5	2,135	4.0	528	1.0
SAMPSON COUNTY	8,385	16.9	5,97	12.0	3,956	8.0	1,597	3.2	418	0.8
SCOTLAND COUNTY	4,276	13.2	2,9	9.1	2,041	6.3	704	2.2	186	0.6
STANLY COUNTY	8,611	17.7	5,999	12.4	4,029	8.3	1,582	3.3	388	0.8
STOKES COUNTY	4,610	13.9	3,296	10.0	2,061	6.2	965	2.9	270	0.8
SURRY COUNTY	10,284	17.3	7,344	12.4	4,565	7.7	2,168	3.6	611	1.0
SWAIN COUNTY	1,980	19.3	1,493	14.5	893	8.7	450	4.4	150	1.5
TRANSYLVANIA COUNTY	4,172	17.8	2,940	12.6	1,956	8.4	758	3.2	226	1.0
TYRRELL COUNTY	841	21.2	597	15.0	401	10.1	165	4.2	31	0.8
UNION COUNTY	9,052	12.9	6,320	9.0	4,067	5.8	1,748	2.5	505	0.7
VANCE COUNTY	6,042	16.4	4,312	11.7	2,724	7.4	1,196	3.3	392	1.1
WAKE COUNTY	32,365	10.7	22,269	7.4	14,116	4.7	6,437	2.1	1,716	0.6
WARREN COUNTY	3,253	20.0	2,395	14.8	1,463	9.0	734	4.5	198	1.2
WASHINGTON COUNTY	2,165	14.6	1,529	10.3	997	6.7	447	3.0	85	0.6
WATAUGA COUNTY	4,146	13.1	3,025	9.6	1,772	5.6	932	2.9	321	1.0
WAYNE COUNTY	12,037	12.4	8,361	8.6	5,455	5.6	2,308	2.4	598	0.6
WILKES COUNTY	8,677	14.8	6,113	10.4	3,927	6.7	1,700	2.9	486	0.8
WILSON COUNTY	9,293	14.7	6,471	10.2	4,261	6.7	1,800	2.9	410	0.6
YADKIN COUNTY	4,966	17.5	3,555	12.5	2,219	7.8	1,104	3.9	232	0.8
YANCEY COUNTY	2,898	19.4	2,108	14.1	1,336	8.9	582	3.9	190	1.3
NORTH DAKOTA	108,387	16.6	80,445	12.3	47,147	7.2	25,158	3.9	8,140	1.2
ADAMS COUNTY	790	22.0	583	16.3	343	9.6	176	4.9	64	1.8
BARNES COUNTY	3,151	22.6	2,403	17.2	1,371	9.8	754	5.4	278	2.0
BENSON COUNTY	1,566	19.7	1,176	14.8	713	9.0	360	4.5	103	1.3
BILLINGS COUNTY	158	13.9	97	8.5	87	7.6	10	0.9	0	0.0
BOTTINEAU COUNTY	2,136	23.1	1,621	17.5	971	10.5	492	5.3	158	1.7
BOWMAN COUNTY	753	17.8	571	13.5	350	8.3	163	3.9	58	1.4
BURKE COUNTY	990	25.9	737	19.3	476	12.5	214	5.6	47	1.2
BURLEIGH COUNTY	6,408	11.7	4,599	8.4	2,787	5.1	1,398	2.6	414	0.8
CASS COUNTY	11,500	13.0	8,438	9.6	4,694	5.3	2,757	3.1	987	1.1
CAVALIER COUNTY	1,693	22.2	1,302	17.1	746	9.8	427	5.6	129	1.7
DICKEY COUNTY	1,653	22.9	1,234	17.1	665	9.2	392	5.4	177	2.5
DIVIDE COUNTY	999	28.6	705	20.2	433	12.4	183	5.2	89	2.5
DUNN COUNTY	794	17.2	532	11.5	373	8.1	138	3.0	21	0.5
EDDY COUNTY	948	26.7	729	20.5	406	11.4	246	6.9	77	2.2
EMMONS COUNTY	1,219	20.7	912	15.5	545	9.3	291	5.0	76	1.3
FOSTER COUNTY	993	21.5	761	16.5	421	9.1	242	5.2	98	2.1
GOLDEN VALLEY COUNTY	528	22.1	386	16.1	222	9.3	125	5.2	39	1.6
GRAND FORKS COUNTY	7,100	10.7	5,254	7.9	2,898	4.4	1,741	2.6	615	0.9
GRANT COUNTY	889	20.8	663	15.5	475	11.1	159	3.7	28	0.7
GRIGGS COUNTY	967	26.0	745	20.1	438	11.8	225	6.1	82	2.2
HETTINGER COUNTY	940	22.0	678	15.9	460	10.8	176	4.1	42	1.0
KIDDER COUNTY	790	20.6	552	14.4	354	9.2	159	4.1	39	1.0
LA MOURE COUNTY	1,532	23.7	1,170	18.1	702	10.8	349	5.4	119	1.8
LOGAN COUNTY	802	23.0	585	16.7	383	11.0	170	4.9	32	0.9
MCHENRY COUNTY	1,885	24.0	1,448	18.4	918	11.7	447	5.7	83	1.1
MCINTOSH COUNTY	1,427	28.7	1,097	22.9	623	13.0	379	7.9	95	2.0
MCKENZIE COUNTY	1,086	15.2	744	10.4	483	6.8	154	2.2	107	1.5
MCLEAN COUNTY	2,464	19.9	1,783	14.4	1,139	9.2	463	3.7	181	1.5
MERCER COUNTY	1,366	14.5	961	10.2	629	6.7	259	2.8	73	0.8
MORTON COUNTY	3,680	14.6	2,716	10.8	1,588	6.3	883	3.5	245	1.0
MOUNTRAIL COUNTY	1,639	21.3	1,182	15.4	713	9.3	335	4.4	134	1.7
NELSON COUNTY	1,521	29.1	1,204	23.0	604	11.5	439	8.4	161	3.1
OLIVER COUNTY	316	12.7	208	8.4	147	5.9	50	2.0	12	0.5
PEMBINA COUNTY	2,262	21.8	1,720	16.5	936	9.0	593	5.7	191	1.8
PIERCE COUNTY	1,404	22.8	1,114	18.1	665	10.8	325	5.3	124	2.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
RAMSEY COUNTY	2,724	20.9	2,086	16.0	1,162	8.9	705	5.4	219	1.7
RANSOM COUNTY	1,663	24.8	1,278	19.1	673	10.0	451	6.7	154	2.3
RENVILLE COUNTY	798	22.1	628	17.4	397	11.0	167	4.6	64	1.8
RICHLAND COUNTY	3,586	18.7	2,773	14.4	1,508	7.9	953	5.0	312	1.6
ROLETTE COUNTY	1,605	13.2	1,141	9.4	726	6.0	335	2.8	80	0.7
SARGENT COUNTY	1,090	19.8	816	14.8	469	8.5	269	4.9	78	1.4
SHERIDAN COUNTY	635	22.5	457	16.2	280	9.9	138	4.9	39	1.4
SIOUX COUNTY	310	8.6	196	5.4	126	3.5	59	1.6	11	0.3
SLOPE COUNTY	202	17.5	131	11.3	82	7.1	42	3.6	7	0.6
STARK COUNTY	3,205	13.5	2,323	9.8	1,418	6.0	702	3.0	203	0.9
STEELE COUNTY	698	22.5	505	16.3	294	9.5	166	5.3	45	1.4
STUTSMAN COUNTY	4,317	17.9	3,238	13.4	1,867	7.7	1,083	4.5	288	1.2
TOWNER COUNTY	1,046	25.8	802	19.8	463	11.4	268	6.6	71	1.8
TRAILL COUNTY	2,376	24.7	1,845	19.2	962	10.0	645	6.7	238	2.5
WALSH COUNTY	3,424	22.3	2,514	16.4	1,395	9.1	827	5.4	292	1.9
WARD COUNTY	7,181	12.3	5,267	9.0	3,269	5.6	1,493	2.6	505	0.9
WELLS COUNTY	1,807	25.9	1,413	20.2	823	11.8	471	6.7	119	1.7
WILLIAMS COUNTY	3,371	15.2	2,421	10.9	1,474	6.6	710	3.2	237	1.1
OHIO	1,658,023	15.4	1,169,460	10.8	706,554	6.5	354,480	3.3	108,426	1.0
ADAMS COUNTY	4,180	17.2	3,109	12.8	1,876	7.7	957	3.9	276	1.1
ALLEN COUNTY	17,610	15.7	12,486	11.1	7,284	6.5	3,841	3.4	1,361	1.2
ASHLAND COUNTY	7,503	16.2	5,431	11.8	3,235	7.0	1,625	3.5	571	1.2
ASHTABULA COUNTY	17,411	16.7	12,335	11.8	7,572	7.3	3,538	3.4	1,225	1.2
ATHENS COUNTY	7,359	13.0	5,411	9.6	3,197	5.7	1,719	3.0	495	0.9
AUGLAIZE COUNTY	6,967	16.4	5,019	11.8	2,894	6.8	1,638	3.8	487	1.1
BELMONT COUNTY	16,478	20.0	11,635	14.1	7,332	8.9	3,336	4.0	967	1.2
BROWN COUNTY	5,261	16.5	3,893	12.2	2,259	7.1	1,229	3.9	405	1.3
BUTLER COUNTY	32,291	12.5	22,907	8.9	13,676	5.3	7,205	2.8	2,026	0.8
CARROLL COUNTY	3,870	15.1	2,688	10.5	1,599	6.2	835	3.3	254	1.0
CHAMPAIGN COUNTY	5,490	16.3	3,908	11.6	2,374	7.1	1,115	3.3	419	1.2
CLARK COUNTY	24,115	16.1	17,174	11.4	10,322	6.9	5,152	3.4	1,700	1.1
CLERMONT COUNTY	13,249	10.3	8,967	7.0	5,542	4.3	2,679	2.1	746	0.6
CLINTON COUNTY	5,555	16.1	3,994	11.5	2,289	6.6	1,257	3.6	448	1.3
COLUMBIANA COUNTY	19,051	16.8	13,382	11.8	8,268	7.3	3,883	3.4	1,231	1.1
COSHOCTON COUNTY	6,297	17.5	4,514	12.5	2,709	7.5	1,376	3.8	429	1.2
CRAWFORD COUNTY	8,394	16.8	6,085	12.2	3,526	7.0	1,896	3.8	663	1.3
CUYAHOGA COUNTY	274,388	18.3	191,962	12.8	118,687	7.9	56,696	3.8	16,579	1.1
DARKE COUNTY	9,390	17.0	6,853	12.4	3,871	7.0	2,201	4.0	781	1.4
DEFIANCE COUNTY	5,312	13.3	3,741	9.4	2,118	5.3	1,183	3.0	440	1.1
DELAWARE COUNTY	6,660	12.4	4,773	8.9	2,852	5.3	1,450	2.7	471	0.9
ERIE COUNTY	12,003	15.1	8,326	10.5	5,073	6.4	2,448	3.1	805	1.0
FAIRFIELD COUNTY	12,991	13.9	9,376	10.0	5,620	6.0	2,873	3.1	883	0.9
FAYETTE COUNTY	4,766	17.4	3,494	12.7	2,043	7.4	1,059	3.9	392	1.4
FRANKLIN COUNTY	107,605	12.4	75,232	8.7	45,447	5.2	22,959	2.6	6,826	0.8
FULTON COUNTY	5,427	14.4	3,949	10.5	2,195	5.8	1,339	3.5	415	1.1
GALLIA COUNTY	4,772	15.9	3,538	11.8	2,226	7.4	1,066	3.5	246	0.8
GEAUGA COUNTY	8,576	11.5	5,582	7.5	3,683	4.9	1,416	1.9	483	0.6
GREENE COUNTY	13,183	10.2	8,683	6.7	5,256	4.1	2,570	2.0	857	0.7
GUERNSEY COUNTY	7,895	18.8	5,788	13.8	3,340	7.9	1,823	4.3	625	1.5
HAMILTON COUNTY	143,514	16.4	104,459	12.0	62,336	7.1	32,491	3.7	9,632	1.1
HANCOCK COUNTY	10,026	15.5	7,245	11.2	4,210	6.5	2,282	3.5	753	1.2
HARDIN COUNTY	5,221	16.0	3,859	11.8	2,193	6.7	1,246	3.8	420	1.3
HARRISON COUNTY	3,496	19.3	2,501	13.8	1,517	8.4	751	4.1	233	1.3
HENRY COUNTY	4,714	16.6	3,490	12.3	1,937	6.8	1,170	4.1	383	1.3
HIGHLAND COUNTY	6,398	19.1	4,745	14.2	2,799	8.4	1,487	4.4	459	1.4
HOCKING COUNTY	4,003	16.5	2,937	12.1	1,774	7.3	897	3.7	266	1.1
HOLMES COUNTY	3,969	13.5	2,978	10.1	1,703	5.8	928	3.2	347	1.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
HURON COUNTY	7,924	14.5	5,657	10.4	3,329	6.1	1,785	3.3	543	1.0
JACKSON COUNTY	5,336	17.4	3,936	12.9	2,325	7.6	1,238	4.0	373	1.2
JEFFERSON COUNTY	16,980	18.5	11,800	12.9	7,581	8.3	3,292	3.6	927	1.0
KNOX COUNTY	7,929	17.1	5,774	12.5	3,425	7.4	1,781	3.8	568	1.2
LAKE COUNTY	26,194	12.3	17,056	8.0	11,015	5.2	4,649	2.2	1,392	0.7
LAWRENCE COUNTY	9,902	15.5	7,010	11.0	4,359	6.8	2,061	3.2	590	0.9
LICKING COUNTY	17,288	14.3	12,312	10.2	7,384	6.1	3,709	3.1	1,219	1.0
LOGAN COUNTY	7,142	18.2	5,089	13.0	3,026	7.7	1,591	4.1	472	1.2
LORAIN COUNTY	34,501	12.5	23,274	8.5	14,467	5.3	6,582	2.4	2,225	0.8
LUCAS COUNTY	75,884	16.1	54,732	11.6	32,477	6.9	17,076	3.6	5,179	1.1
MADISON COUNTY	4,375	13.3	3,027	9.2	1,849	5.6	909	2.8	269	0.8
MAHONING COUNTY	52,184	18.0	35,785	12.4	21,836	7.5	10,671	3.7	3,278	1.1
MARION COUNTY	9,616	14.1	6,866	10.1	4,081	6.0	2,137	3.1	648	1.0
MEDINA COUNTY	11,603	10.3	8,068	7.1	4,756	4.2	2,463	2.2	849	0.8
MEIGS COUNTY	4,248	18.0	3,054	12.9	1,804	7.6	980	4.1	270	1.1
MERCER COUNTY	5,909	15.4	4,195	10.9	2,494	6.5	1,286	3.4	415	1.1
MIAMI COUNTY	13,586	15.0	9,585	10.6	5,754	6.4	2,908	3.2	923	1.0
MONROE COUNTY	3,063	17.6	2,291	13.2	1,342	7.7	718	4.1	231	1.3
MONTGOMERY COUNTY	82,681	14.5	57,153	10.0	35,157	6.1	17,000	3.0	4,996	0.9
MORGAN COUNTY	2,773	19.5	2,041	14.3	1,148	8.1	615	4.3	278	2.0
MORROW COUNTY	3,679	13.9	2,659	10.0	1,685	6.4	726	2.7	248	0.9
MUSKINGUM COUNTY	13,976	16.8	10,162	12.2	6,010	7.2	3,214	3.9	938	1.1
NOBLE COUNTY	2,208	19.5	1,682	14.9	971	8.6	531	4.7	180	1.6
OTTAWA COUNTY	6,913	17.2	4,785	11.9	3,068	7.7	1,354	3.4	363	0.9
PAULDING COUNTY	2,891	13.6	2,027	9.5	1,226	5.8	626	2.9	175	0.8
PERRY COUNTY	4,974	16.0	3,590	11.6	2,147	6.9	1,121	3.6	322	1.0
PICKAWAY COUNTY	5,680	13.0	3,887	8.9	2,449	5.6	1,148	2.6	290	0.7
PIKE COUNTY	3,950	17.3	2,965	13.0	1,721	7.5	967	4.2	277	1.2
PORTAGE COUNTY	14,226	10.5	9,652	7.1	5,973	4.4	2,789	2.1	890	0.7
PREBLE COUNTY	5,827	15.2	4,141	10.8	2,507	6.6	1,238	3.2	396	1.0
PUTNAM COUNTY	4,833	14.6	3,524	10.7	2,014	6.1	1,124	3.4	386	1.2
RICHLAND COUNTY	19,189	14.6	13,439	10.2	8,258	6.3	4,044	3.1	1,137	0.9
ROSS COUNTY	10,299	15.8	7,249	11.2	4,351	6.7	2,256	3.5	642	1.0
SANDUSKY COUNTY	9,474	15.0	6,685	10.6	3,990	6.3	2,085	3.3	610	1.0
SCIOTO COUNTY	15,164	17.9	11,139	13.2	6,537	7.7	3,656	4.3	946	1.1
SENECA COUNTY	9,615	15.5	6,913	11.2	3,982	6.4	2,107	3.4	824	1.3
SHELBY COUNTY	6,055	14.1	4,314	10.0	2,554	5.9	1,298	3.0	462	1.1
STARK COUNTY	60.540	16.0	42,360	11.2	25,344	6.7	12,944	3.4	4,072	1.1
SUMMIT COUNTY	84,103	16.0	58,965	11.2	35,101	6.7	18,508	3.5	5,356	1.0
TRUMBULL COUNTY	36,874	15.2	24,746	10.2	15,689	6.5	6,931	2.9	2,126	0.9
TUSCARAWAS COUNTY	14,998	17.7	10,874	12.9	6,374	7.5	3,508	4.1	992	1.2
UNION COUNTY	4,286	14.5	3,089	10.5	1,803	6.1	969	3.3	317	1.1
VAN WERT COUNTY	5,486	18.0	4,083	13.4	2,322	7.6	1,324	4.3	437	1.4
VINTON COUNTY	1,943	16.8	1,438	12.4	881	7.6	431	3.7	126	1.1
WARREN COUNTY	10,363	10.4	7,159	7.2	4,248	4.3	2,096	2.1	815	0.8
WASHINGTON COUNTY	9,939	15.5	7,161	11.1	4,101	6.4	2,286	3.6	774	1.2
WAYNE COUNTY	13,135	13.5	9,283	9.5	5,347	5.5	2,899	3.0	1,037	1.1
WILLIAMS COUNTY	6,009	16.5	4,311	11.9	2,376	6.5	1,463	4.0	472	1.3
WOOD COUNTY	12,854	12.0	8,988	8.4	5,387	5.0	2,760	2.6	821	0.8
WYANDOT COUNTY	4,032	17.8	3,036	13.4	1,695	7.5	990	4.4	351	1.5
OKLAHOMA	506,754	16.8	376,126	12.4	224,733	7.4	117,412	3.9	33,981	1.1
ADAIR COUNTY	3,376	18.2	2,500	13.5	1,495	8.0	800	4.3	205	1.1
ALFALFA COUNTY	2,098	29.6	1,677	23.7	912	12.9	582	8.2	183	2.6
ATOKA COUNTY	2,564	20.1	1,935	15.2	1,189	9.4	571	4.5	165	1.3
BEAVER COUNTY	1,353	19.9	975	14.3	620	9.1	274	4.0	81	1.2
BECKHAM COUNTY	4,502	23.4	3,554	18.5	2,045	10.6	1,149	6.0	360	1.9
BLAINE COUNTY	3,181	23.7	2,445	18.2	1,345	10.0	808	6.0	292	2.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
BRYAN COUNTY	6,678	21.9	5,114	16.7	3,017	9.9	1,643	5.4	454	1.5
CADDO COUNTY	6,654	21.5	5,129	16.6	3,097	10.0	1,530	5.0	502	1.6
CANADIAN COUNTY	6,232	11.0	4,556	8.1	2,616	4.6	1,504	2.7	436	0.8
CARTER COUNTY	8,844	20.3	6,755	15.5	4,001	9.2	2,147	4.9	607	1.4
CHEROKEE COUNTY	5,153	16.8	3,798	12.4	2,328	7.6	1,123	3.7	347	1.1
CHOCTAW COUNTY	3,877	22.5	2,984	17.3	1,827	10.6	926	5.4	231	1.3
CIMARRON COUNTY	771	21.1	559	15.3	342	9.4	166	4.6	51	1.4
CLEVELAND COUNTY	10,843	8.1	7,690	5.8	4,774	3.6	2,286	1.7	630	0.5
COAL COUNTY	1,502	24.9	1,182	19.6	675	11.2	399	6.6	108	1.8
COMANCHE COUNTY	10,692	9.5	7,343	6.5	4,629	4.1	2,087	1.9	627	0.6
COTTON COUNTY	1,881	25.6	1,402	19.1	798	10.9	446	6.1	158	2.2
CRAIG COUNTY	3,520	23.4	2,685	17.9	1,585	10.6	854	5.7	246	1.6
CREEK COUNTY	9,545	16.2	7,050	11.9	4,186	7.1	2,191	3.7	673	1.1
CUSTER COUNTY	4,504	17.3	3,475	13.4	2,015	7.8	1,113	4.3	347	1.3
DELAWARE COUNTY	6,038	25.2	4,410	18.4	2,907	12.1	1,212	5.1	291	1.2
DEWEY COUNTY	1,565	26.4	1,216	20.5	714	12.1	369	6.2	133	2.2
ELLIS COUNTY	1,356	24.2	1,044	18.7	652	11.7	305	5.5	87	1.6
GARFIELD COUNTY	10,868	17.3	8,237	13.1	4,755	7.6	2,695	4.3	787	1.3
GARVIN COUNTY	6,669	23.9	5,174	18.6	3,116	11.2	1,580	5.7	478	1.7
GRADY COUNTY	7,179	18.2	5,458	13.8	3,221	8.2	1,727	4.4	510	1.3
GRANT COUNTY	1,928	29.6	1,489	22.8	846	13.0	473	7.3	170	2.6
GREER COUNTY	2,269	32.3	1,861	26.5	1,008	14.3	653	9.3	200	2.8
HARMON COUNTY	1,412	31.2	1,120	24.8	633	14.0	373	8.3	114	2.5
HARPER COUNTY	1,111	23.6	865	18.3	519	11.0	272	5.8	74	1.6
HASKELL COUNTY	2,597	23.6	1,941	17.6	1,194	10.8	593	5.4	154	1.4
HUGHES COUNTY	3,898	27.2	3,073	21.4	1,803	12.6	997	7.0	273	1.9
JACKSON COUNTY	4,499	14.8	3,380	11.1	2,009	6.6	1,055	3.5	316	1.0
JEFFERSON COUNTY	2,137	26.1	1,676	20.5	945	11.5	559	6.8	172	2.1
JOHNSTON COUNTY	2,369	22.9	1,806	17.4	1,089	10.5	579	5.6	138	1.3
KAY COUNTY	10,655	21.4	8,066	16.2	4,536	9.1	2,689	5.4	841	1.7
KINGFISHER COUNTY	2,693	19.0	2,132	15.0	1,212	8.5	680	4.8	240	1.7
KIOWA COUNTY	3,608	28.4	2,833	22.3	1,627	12.8	536	7.4	270	2.1
LATIMER COUNTY	2,098	21.3	1,565	15.9	937	9.5	476	4.8	152	1.5
LE FLORE COUNTY	8,095	19.9	6,204	15.2	3,703	9.1	1,933	4.7	568	1.4
LINCOLN COUNTY	5,245	19.7	4,064	15.3	2,417	9.1	1,309	4.9	338	1.3
LOGAN COUNTY	4,947	18.4	3,814	14.2	2,089	7.8	1,292	4.8	433	1.6
LOVE COUNTY	1,640	22.0	1,217	16.3	781	10.5	354	4.7	82	1.1
MCCLAIN COUNTY	3,198	15.8	2,401	11.8	1,412	7.0	775	3.8	214	1.1
MCCURTAIN COUNTY	6,240	17.3	4,697	13.0	2,864	7.9	1,478	4.1	355	1.0
MCINTOSH COUNTY	4,189	26.9	3,126	20.1	1,977	12.7	871	5.6	278	1.8
MAJOR COUNTY	1,888	21.5	1,466	16.7	835	9.5	481	5.5	150	1.7
MARSHALL COUNTY	3,008	28.5	2,244	21.3	1,432	13.6	645	6.1	167	1.6
MAYES COUNTY	6,363	19.7	4,698	14.6	2,928	9.1	1,391	4.3	379	1.2
MURRAY COUNTY	2,826	23.3	2,215	18.2	1,282	10.6	734	6.0	199	1.6
MUSKOGEE COUNTY	13,147	19.6	9,808	14.7	5,704	8.5	3,086	4.6	1,018	1.5
NOBLE COUNTY	2,439	21.1	1,922	16.6	1,058	9.1	682	5.9	182	1.6
NOWATA COUNTY	2,568	22.4	1,938	16.9	1,148	10.0	613	5.3	177	1.5
OKFUSKEE COUNTY	2,818	25.3	2,172	19.5	1,328	11.9	652	5.9	192	1.7
OKLAHOMA COUNTY	82,874	14.6	59,532	10.5	36,368	6.4	18,229	3.2	4,935	0.9
OKMULGEE COUNTY	8,369	21.4	6,402	16.3	3,705	9.5	2,082	5.3	615	1.6
OSAGE COUNTY	6,895	17.5	5,052	12.8	3,107	7.9	1,507	3.8	438	1.1
OTTAWA COUNTY	6,355	19.3	4,610	14.1	2,861	8.7	1,356	4.1	402	1.2
PAWNEE COUNTY	3,138	20.5	2,358	15.4	1,345	8.8	786	5.1	227	1.5
PAYNE COUNTY	8,104	13.0	6,157	9.9	3,553	5.7	2,003	3.2	601	1.0
PITTSBURG COUNTY	8,947	22.1	6,711	16.6	4,009	9.9	2,071	5.1	631	1.6
PONTOTOC COUNTY	6,991	21.4	5,390	16.5	3,143	9.6	1,788	5.5	459	1.4
POTTAWATOMIE COUNTY	10,487	19.0	7,891	14.5	4.658	8.4	2,577	4.7	756	1.4

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
PUSHMATAHA COUNTY	2,663	22.6	2,063	17.5	1,294	11.0	632	5.4	137	1.2
ROGER MILLS COUNTY	1,134	23.6	839	17.5	522	10.9	260	5.4	57	1.2
ROGERS COUNTY	5,750	12.4	4,143	8.9	2,549	5.5	1,214	2.6	380	0.8
SEMINOLE COUNTY	6,224	22.7	4,794	17.4	2,826	10.3	1,629	5.9	339	1.2
SEQUOYAH COUNTY	5,288	17.2	3,896	12.7	2,370	7.7	1,181	3.8	345	1.1
STEPHENS COUNTY	8,694	20.0	6,549	15.1	3,907	9.0	2,069	4.8	573	1.3
TEXAS COUNTY	2,604	14.7	1,849	10.4	1,159	6.5	524	3.0	166	0.9
TILLMAN COUNTY	3,023	24.4	2,296	18.5	1,376	11.1	705	5.7	215	1.7
TULSA COUNTY	65,132	13.8	46,546	9.9	27,665	5.9	14,588	3.1	4,293	0.9
WAGONER COUNTY	5,217	12.5	3,743	9.0	2,422	5.8	1,000	2.4	321	0.8
WASHINGTON COUNTY	8,527	17.7	6,190	12.9	3,676	7.6	1,907	4.0	607	1.3
WASHITA COUNTY	3,015	21.9	2,288	16.6	1,333	9.7	723	5.2	232	1.7
WOODS COUNTY	2,855	26.1	2,228	20.4	1,259	11.5	754	6.9	215	2.0
WOODWARD COUNTY	3,138	14.8	2,350	11.1	1,439	6.8	709	3.3	202	1.0
OREGON	421,026	16.0	303,336	11.5	184,554	7.0	90,351	3.4	28,431	1.1
BAKER COUNTY	3,491	21.6	2,561	15.9	1,536	9.5	779	4.8	246	1.5
BENTON COUNTY	7,155	10.5	5,137	7.5	2,940	4.3	1,610	2.4	587	0.9
CLACKAMAS COUNTY	32,079	13.3	22,664	9.4	13,879	5.7	6,569	2.7	2,216	0.9
CLATSOP COUNTY	6,529	20.1	4,745	14.6	2,917	9.0	1,387	4.3	441	1.4
COLUMBIA COUNTY	5,622	15.8	3,930	11.0	2,435	6.8	1,166	3.3	329	0.9
COOS COUNTY	11,032	17.2	7,734	12.1	5,009	7.8	2,121	3.3	604	0.9
CROOK COUNTY	2,352	18.0	1,641	12.5	1,105	8.4	424	3.2	112	0.9
CURRY COUNTY	4,106	24.2	2,872	16.9	2,049	12.1	660	3.9	163	1.0
DESCHUTES COUNTY	9,074	14.6	6,272	10.1	4,236	6.8	1,617	2.6	419	0.7
DOUGLAS COUNTY	14,578	15.6	10,165	10.8	6,562	7.0	2,848	3.0	755	0.8
GILLIAM COUNTY	389	18.9	291	14.1	195	9.5	69	3.4	27	1.3
GRANT COUNTY	1,430	17.4	1,004	12.2	610	7.4	307	3.7	87	1.1
HARNEY COUNTY	1,188	14.3	830	10.0	530	6.4	231	2.8	69	0.8
HOOD RIVER COUNTY	2,767	17.5	1,957	12.4	1,258	7.9	544	3.4	155	1.0
JACKSON COUNTY	23,155	17.5	16,720	12.6	10,477	7.9	4,767	3.6	1,476	1.1
JEFFERSON COUNTY	1,618	13.9	1,090	9.4	782	6.7	230	2.0	78	0.7
JOSEPHINE COUNTY	12,365	20.8	8,966	15.2	5,720	9.7	2,534	4.3	712	1.2
KLAMATH COUNTY	8,943	15.1	6,264	10.6	4,122	7.0	1,722	2.9	420	0.7
LAKE COUNTY	1,200	15.9	835	11.1	533	7.1	247	3.3	55	0.7
LANE COUNTY	37,350	13.6	26,338	9.6	16,185	5.9	7,726	2.8	2,427	0.9
LINCOLN COUNTY	8,372	23.7	5,890	16.7	3,953	11.2	1,552	4.4	385	1.1
LINN COUNTY	14,163	15.8	10,058	11.2	6,254	7.0	2,800	3.1	1,004	1.1
MALHEUR COUNTY	4,648	17.3	3,340	12.4	2,004	7.5	1,021	3.8	315	1.2
MARION COUNTY	34,527	16.9	25,754	12.6	15,145	7.4	8,171	4.0	2,438	1.2
MORROW COUNTY	998	13.3	701	9.3	464	6.2	188	2.5	49	0.7
MULTNOMAH COUNTY	101,815	18.1	75,049	13.3	43,064	7.7	23,801	4.2	8,184	1.5
POLK COUNTY	7,705	17.0	5,702	12.6	3,270	7.2	1,892	4.2	540	1.2
SHERMAN COUNTY	411	18.9	263	12.1	188	8.7	57	2.6	18	0.8
TILLAMOOK COUNTY	4,677	22.1	3,350	15.8	2,180	10.3	928	4.4	242	1.1
UMATILLA COUNTY	9,318	15.8	6,695	11.4	4,125	7.0	1,986	3.4	584	1.0
UNION COUNTY	3,894	16.3	2,879	12.0	1,723	7.2	851	3.6	305	1.3
WALLOWA COUNTY	1,470	20.2	1,080	14.8	654	9.0	332	4.6	94	1.3
WASCO COUNTY	4,136	19.0	3,049	14.0	1,847	8.5	894	4.1	308	1.4
WASHINGTON COUNTY	28,871	11.7	20,388	8.3	12,521	5.1	6,055	2.5	1,812	0.7
WHEELER COUNTY	371	24.5	262	17.3	158	10.4	80	5.3	24	1.6
YAMHILL COUNTY	9,327	16.9	6,860	12.4	3,924	7.1	2,185	3.9	751	1.4
PENNSYLVANIA	2,163,914	18.2	1,530,933	12.9	944,065	8.0	456,908	3.9	129,960	1.1
ADAMS COUNTY	10,857	15.9	7,748	11.3	4,654	6.8	2,319	3.4	775	1.1
ALLEGHENY COUNTY	285,391	19.7	199,566	13.8	124,046	8.6	58,910	4.1	16,610	1.1
ARMSTRONG COUNTY	15,492	19.9	11,093	14.3	6,800	8.7	3,349	4.3	944	1.2
BEAVER COUNTY	36,078	17.6	24,305	11.9	15,676	7.7	6,723	3.3	1,906	0.9
BEDFORD COUNTY	8,299	17.7	5,893	12.6	3,680	7.9	1,693	3.6	520	1.1

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
BERKS COUNTY	61,234	19.6	44,171	14.1	27,019	8.6	13,533	4.3	3,619	1.2
BLAIR COUNTY	26,777	19.6	19,482	14.3	11,539	8.4	6,102	4.5	1,841	1.3
BRADFORD COUNTY	10,551	16.8	7,657	12.2	4,452	7.1	2,421	3.8	784	1.2
BUCKS COUNTY	58,047	12.1	38,299	8.0	23,595	4.9	11,178	2.3	3,526	0.7
BUTLER COUNTY	22,586	15.3	15,793	10.7	9,472	6.4	4,644	3.1	1,677	1.1
CAMBRIA COUNTY	36,008	19.6	25,039	13.7	16,002	8.7	7,023	3.8	2,014	1.1
CAMERON COUNTY	1,332	20.0	953	14.3	613	9.2	250	3.7	90	1.3
CARBON COUNTY	11,830	22.2	8,327	15.6	5,338	10.0	2,354	4.4	635	1.2
CENTRE COUNTY	12,060	10.7	8,542	7.6	5,271	4.7	2,543	2.3	728	0.6
CHESTER COUNTY	41,924	13.2	28,686	9.1	17,467	5.5	8,537	2.7	2,682	0.8
CLARION COUNTY	6,986	16.1	5,067	11.7	2,928	6.8	1,690	3.9	449	1.0
CLEARFIELD COUNTY	15,406	18.4	10,933	13.1	6,753	8.1	3,325	4.0	855	1.0
CLINTON COUNTY	6,711	17.2	4,723	12.1	2,946	7.6	1,416	3.6	361	0.9
COLUMBIA COUNTY	11,503	18.6	8,262	13.3	5,138	8.3	2,442	3.9	682	1.1
CRAWFORD COUNTY	15,945	17.9	11,481	12.9	6,871	7.7	3,419	3.8	1,191	1.3
CUMBERLAND COUNTY	27,312	15.3	19,086	10.7	11,252	6.3	5,887	3.3	1,947	1.1
DAUPHIN COUNTY	41,139	17.7	29,145	12.5	18,024	7.8	8,484	3.7	2,637	1.1
DELAWARE COUNTY	102,183	18.4	71,322	12.8	43,234	7.8	21,826	3.9	6,262	1.1
ELK COUNTY	6,794	17.7	4,765	12.4	2,980	7.8	1,384	3.6	401	1.0
ERIE COUNTY	44,241	15.8	30,536	10.9	18,844	6.7	8,861	3.2	2,831	1.0
FAYETTE COUNTY	31,951	20.0	22,693	14.2	14,244	8.9	6,692	4.2	1,757	1.1
FOREST COUNTY	1,157	22.8	842	16.6	568	11.2	225	4.4	49	1.0
FRANKLIN COUNTY	19,101	16.8	13,705	12.1	8,215	7.2	4,202	3.7	1,288	1.1
FULTON COUNTY	2,049	16.0	1,457	11.3	932	7.3	412	3.2	113	0.9
GREENE COUNTY	7,787	19.2	5,598	13.8	3,449	8.5	1,662	4.1	487	1.2
HUNTINGDON COUNTY	7,230	17.1	5,275	12.5	3,284	7.8	1,610	3.8	381	0.9
INDIANA COUNTY	14,431	15.6	10,167	11.0	6,277	6.8	2,950	3.2	940	1.0
JEFFERSON COUNTY	9,586	19.8	7,037	14.6	4,217	8.7	2,144	4.4	676	1.4
JUNIATA COUNTY	3,337	17.4	2,417	12.6	1,459	7.6	720	3.8	238	1.2
LACKAWANNA COUNTY	51,817	22.7	37,235	16.3	23,642	10.4	10,947	4.8	2,646	1.2
LANCASTER COUNTY	58,233	16.1	42,338	11.7	24,514	6.8	13,418	3.7	4,406	1.2
LAWRENCE COUNTY	20,700	19.3	14,440	13.5	8,876	8.3	4,249	4.0	1,315	1.2
LEBANON COUNTY	19,017	17.5	13,634	12.6	8,214	7.6	4,094	3.8	1,326	1.2
LEHIGH COUNTY	50,379	18.5	35,404	13.0	21,936	8.1	10,471	3.8	2,997	1.1
LUZERNE COUNTY	78,423	22.9	56,119	16.4	36,434	10.6	15,982	4.7	3,703	1.1
LYCOMING COUNTY	20,922	17.7	15,110	12.8	8,921	7.5	4,715	4.0	1,474	1.2
MCKEAN COUNTY	10,449	20.6	7,771	15.3	4,684	9.3	2,477	4.9	610	1.2
MERCER COUNTY	23,715	18.5	16,681	13.0	10,004	7.8	4,993	3.9	1,684	1.3
MIFFLIN COUNTY	8,782	18.7	6,318	13.5	4,019	8.6	1,827	3.9	472	1.0
MONROE COUNTY	12,663	18.2	9,067	13.1	5,815	8.4	2,528	3.6	724	1.0
MONTGOMERY COUNTY	114,168	17.7	80,879	12.6	48,052	7.5	25,303	3.9	7,524	1.2
MONTOUR COUNTY	3,494	21.0	2,684	16.1	1,523	9.1	861	5.2	300	1.8
NORTHAMPTON COUNTY	41,323	18.3	28,301	12.6	17,765	7.9	8,138	3.6	2,398	1.1
NORTHUMBERLAND COUNTY	22,309	22.2	16,150	16.1	10,256	10.2	4,767	4.7	1,127	1.1
PERRY COUNTY	5,260	14.7	3,707	10.4	2,284	6.4	1,097	3.1	326	0.9
PHILADELPHIA COUNTY	328,288	19.4	237,370	14.1	146,120	8.7	72,684	4.3	18,566	1.1
PIKE COUNTY	4,577	25.1	3,292	18.0	2,161	11.8	915	5.0	216	1.2
POTTER COUNTY	3,190	18.0	2,302	13.0	1,373	7.7	680	3.8	249	1.4
SCHUYLKILL COUNTY	37,819	23.5	26,955	16.8	17,728	11.0	7,528	4.7	1,699	1.1
SNYDER COUNTY	5,039	15.0	3,544	10.6	2,260	6.7	1,014	3.0	270	0.8
SOMERSET COUNTY	15,326	18.9	10,803	13.3	6,674	8.2	3,160	3.9	969	1.2
SULLIVAN COUNTY	1,415	22.3	1,036	16.3	632	10.0	311	4.9	93	1.5
SUSQUEHANNA COUNTY	6,920	18.3	4,922	13.0	3,062	8.1	1,454	3.8	406	1.1
TIOGA COUNTY	6,843	16.7	4,909	12.0	2,894	7.1	1,523	3.7	492	1.2
UNION COUNTY	4,812	14.6	3,531	10.7	1,985	6.0	1,118	3.4	428	1.3
VENANGO COUNTY	11,352	17.6	8,083	12.5	4,874	7.6	2,533	3.9	676	1.0
WARREN COUNTY	8,872	18.7	6,467	13.6	3,948	8.3	1,938	4.1	581	1.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
WASHINGTON COUNTY	41,729	19.2	28,742	13.2	18,329	8.4	7,934	3.7	2,479	1.1
WAYNE COUNTY	7,479	21.2	5,460	15.5	3,312	9.4	1,632	4.6	516	1.5
WESTMORELAND COUNTY	70,811	18.1	48,711	12.4	31,005	7.9	13,777	3.5	3,929	1.0
WYOMING COUNTY	4,152	15.7	2,959	11.2	1,813	6.9	884	3.3	262	1.0
YORK COUNTY	50,321	16.1	35,944	11.5	21,717	6.9	11,026	3.5	3,201	1.0
RHODE ISLAND	176,373	18.6	126,922	13.4	75,562	8.0	39,382	4.2	11,978	1.3
BRISTOL COUNTY	8,441	18.0	5,865	12.5	3,602	7.7	1,704	3.6	559	1.2
KENT COUNTY	25,308	16.4	17,570	11.4	10,746	7.0	5,304	3.4	1,520	1.0
NEWPORT COUNTY	12,911	15.9	9,240	11.4	5,649	6.9	2,744	3.4	847	1.0
PROVIDENCE COUNTY	116,232	20.3	84,649	14.8	49,643	8.7	26,859	4.7	8,147	1.4
WASHINGTON COUNTY	13,481	14.4	9,598	10.3	5,922	6.3	2,771	3.0	905	1.0
SOUTH CAROLINA	416,144	13.3	287,328	9.2	189,527	6.1	77,797	2.5	20,004	0.6
ABBEVILLE COUNTY	3,855	17.0	2,821	12.5	1,800	8.0	765	3.4	256	1.1
AIKEN COUNTY	14,685	13.9	10,023	9.5	6,705	6.3	2,646	2.5	672	0.6
ALLENDALE COUNTY	1,759	16.4	1,281	12.0	838	7.8	347	3.2	96	0.9
ANDERSON COUNTY	20,487	15.4	14,348	10.8	9,504	7.1	3,931	3.0	913	0.7
BAMBERG COUNTY	2,838	15.7	2,005	11.1	1,315	7.3	544	3.0	146	0.8
BARNWELL COUNTY	2,955	14.9	2,111	10.6	1,325	6.7	606	3.1	180	0.9
BEAUFORT COUNTY	8,158	12.5	5,303	8.1	3,828	5.9	1,162	1.8	313	0.5
BERKELEY COUNTY	7,180	7.6	4,583	4.8	3,283	3.5	1,069	1.1	231	0.2
CALHOUN COUNTY	1,993	16.3	1,411	11.6	909	7.4	404	3.3	98	0.8
CHARLESTON COUNTY	31,774	11.5	21,442	7.7	14,435	5.2	5,548	2.0	1,459	0.5
CHEROKEE COUNTY	5,964	14.6	4,280	10.4	2,743	6.7	1,241	3.0	296	0.7
CHESTER COUNTY	5,045	16.7	3,550	11.8	2,350	7.8	960	3.2	240	0.8
CHESTERFIELD COUNTY	5,742	15.0	4,027	10.6	2,663	7.0	1,123	2.9	241	0.6
CLARENDON COUNTY	4,229	15.4	2,978	10.8	1,993	7.3	802	2.9	183	0.7
COLLETON COUNTY	4,974	15.7	3,546	11.2	2,324	7.3	975	3.1	247	0.8
DARLINGTON COUNTY	8,508	13.6	5,946	9.5	3,944	6.3	1,531	2.4	471	0.8
DILLON COUNTY	4,232	13.6	2,928	9.4	1,978	6.4	752	2.4	198	0.6
DORCHESTER COUNTY	5,423	9.2	3,669	6.2	2,400	4.1	978	1.7	291	0.5
EDGEFIELD COUNTY	2,531	14.4	1,789	10.2	1,128	6.4	518	3.0	143	0.8
FAIRFIELD COUNTY	3,371	16.3	2,441	11.8	1,489	7.2	714	3.4	238	1.1
FLORENCE COUNTY	13,882	12.6	9,482	8.6	6,310	5.7	2,518	2.3	654	0.6
GEORGETOWN COUNTY	5,760	13.6	3,871	9.1	2,729	6.4	921	2.2	221	0.5
GREENVILLE COUNTY	39,651	13.8	27,391	9.5	17,869	6.2	7,640	2.7	1,882	0.7
GREENWOOD COUNTY	9,317	16.1	6,585	11.4	4,252	7.4	1,873	3.2	460	0.8
HAMPTON COUNTY	2,899	16.0	2,044	11.3	1,290	7.1	608	3.3	146	0.8
HORRY COUNTY	13,955	13.8	9,395	9.3	6,490	6.4	2,337	2.3	568	0.6
JASPER COUNTY	2,139	14.7	1,535	10.6	991	6.8	422	2.9	122	0.8
KERSHAW COUNTY	5,560	14.3	3,835	9.8	2,602	6.7	973	2.5	260	0.7
LANCASTER COUNTY	7,506	14.1	5,182	9.7	3,455	5.5	1,372	2.6	355	0.7
LAURENS COUNTY	8,481	16.2	6,015	11.5	3,880	7.4	1,750	3.4	385	0.7
LEE COUNTY	2,666	14.1	1,865	9.9	1,240	6.6	491	2.6	134	0.7
LEXINGTON COUNTY	14,517	10.3	9,581	6.8	6,187	4.4	2,589	1.8	805	0.6
MCCORMICK COUNTY	1,749	16.0	858	11.0	513	6.6	272	3.5	73	0.9
MARION COUNTY	4,952	14.5	3,435	10.1	2,354	6.9	874	2.6	207	0.6
MARLBORO COUNTY	4,642	13.7	3,333	10.5	2,212	7.0	898	2.8	223	0.7
NEWBERRY COUNTY	6,177	19.8	4,458	14.3	2,844	9.1	1,283	4.1	331	1.1
OCONEE COUNTY	7,595	15.6	5,291	10.9	3,508	7.2	1,431	2.9	352	0.7
ORANGEBURG COUNTY	11,900	14.5	8,359	10.2	5,442	6.6	2,283	2.8	634	0.8
PICKENS COUNTY	10,202	12.9	7,044	8.9	4,556	5.7	1,977	2.5	511	0.6
RICHLAND COUNTY	30,048	11.1	20,542	7.6	13,298	4.9	5,717	2.1	1,527	0.6
SALUDA COUNTY	2,818	17.4	2,022	12.5	1,238	7.7	583	3.6	201	1.2
SPARTANBURG COUNTY	30,466	15.1	21,350	10.6	13,974	6.9	5,986	3.0	1,390	0.7
SUMTER COUNTY	9,882	11.2	6,795	7.7	4,413	5.0	1,814	2.1	568	0.6
UNION COUNTY	5,161	16.8	3,659	11.9	2,358	7.7	1,038	3.4	263	0.9
WILLIAMSBURG COUNTY	5,389	14.1	3,674	9.6	2,445	6.4	999	2.6	230	0.6

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
YORK COUNTY	13,627	12.8	9,245	8.7	6,123	5.7	2,532	2.4	590	0.8
SOUTH DAKOTA	122,063	17.7	91,019	13.2	50,515	7.3	30,077	4.4	10,427	1.5
AURORA COUNTY	847	23.3	650	17.9	351	9.7	208	5.7	91	2.5
BEADLE COUNTY	3,807	19.8	2,822	14.7	1,498	7.8	994	5.2	330	1.7
BENNETT COUNTY	446	14.7	323	10.6	194	6.4	113	3.7	16	0.5
BON HOMME COUNTY	1,974	24.5	1,515	18.8	821	10.2	510	6.3	184	2.3
BROOKINGS COUNTY	3,495	14.4	2,605	10.7	1,388	5.7	921	3.8	296	1.2
BROWN COUNTY	6,288	17.0	4,714	12.8	2,562	6.9	1,602	4.3	550	1.5
BRULE COUNTY	1,047	20.0	762	14.5	432	8.2	239	4.6	91	1.7
BUFFALO COUNTY	166	9.2	107	6.0	68	3.8	26	1.4	13	0.7
BUTTE COUNTY	1,616	19.3	1,191	14.2	676	8.1	353	4.2	162	1.9
CAMPBELL COUNTY	515	23.0	380	16.9	227	10.1	132	5.9	21	0.9
CHARLES MIX COUNTY	1,989	20.5	1,507	15.6	847	8.7	492	5.1	168	1.7
CLARK COUNTY	1,253	25.6	921	18.8	514	10.5	329	6.7	78	1.6
CLAY COUNTY	1,700	12.4	1,271	9.3	683	5.0	427	3.1	161	1.2
CODINGTON COUNTY	3,883	18.6	2,912	13.9	1,562	7.5	994	4.8	356	1.7
CORSON COUNTY	611	11.8	429	8.3	296	5.7	97	1.9	36	0.7
CUSTER COUNTY	979	16.3	708	11.8	423	7.0	214	3.6	71	1.2
DAVISON COUNTY	3,569	20.0	2,764	15.5	1,416	7.9	983	5.5	365	2.0
DAY COUNTY	2,096	25.8	1,616	19.9	832	10.2	581	7.1	203	2.5
DEUEL COUNTY	1,249	23.6	946	17.9	537	10.2	302	5.7	107	2.0
DEWEY COUNTY	639	11.9	461	8.6	295	5.5	141	2.6	25	0.5
DOUGLAS COUNTY	961	23.0	744	17.8	434	10.4	227	5.4	83	2.0
EDMUNDS COUNTY	1,242	24.1	953	18.5	517	10.0	316	6.1	120	2.3
FALL RIVER COUNTY	1,933	22.9	1,450	17.2	750	8.9	491	5.8	209	2.5
FAULK COUNTY	764	23.0	594	17.9	328	9.9	202	6.1	64	1.9
GRANT COUNTY	1,902	21.1	1,433	15.9	772	8.6	482	5.3	179	2.0
GREGORY COUNTY	1,495	24.9	1,163	19.3	637	10.6	415	6.9	111	1.8
HAAKON COUNTY	483	17.3	359	12.8	210	7.5	109	3.9	40	1.4
HAMLIN COUNTY	1,445	27.5	1,115	21.2	594	11.3	381	7.2	140	2.7
HAND COUNTY	1,066	21.5	800	16.2	433	8.8	278	5.6	89	1.8
HANSON COUNTY	687	20.1	512	15.0	260	7.6	190	5.6	62	1.8
HARDING COUNTY	324	19.1	223	13.1	149	8.8	57	3.4	17	1.0
HUGHES COUNTY	1,951	13.7	1,384	9.7	805	5.7	410	2.9	169	1.2
HUTCHINSON COUNTY	2,601	27.8	2,043	21.8	1,046	11.2	764	8.2	233	2.5
HYDE COUNTY	496	24.0	386	18.7	217	10.5	116	5.6	53	2.6
JACKSON COUNTY	511	14.9	365	10.6	240	7.0	94	2.7	31	0.9
JERAULD COUNTY	773	26.4	587	20.0	313	10.7	204	7.0	70	2.4
JONES COUNTY	290	19.8	222	15.2	145	9.9	66	4.5	11	0.8
KINGSBURY COUNTY	1,841	27.6	1,413	21.2	705	10.6	497	7.4	211	3.2
LAKE COUNTY	2,442	22.8	1,878	17.5	1,000	9.3	630	5.9	248	2.3
LAWRENCE COUNTY	3,225	17.6	2,394	13.1	1,393	7.6	746	4.1	255	1.4
LINCOLN COUNTY	2,746	19.7	2,120	13.2	1,126	8.1	694	5.0	300	2.2
LYMAN COUNTY	637	16.5	469	12.1	281	7.3	140	3.6	48	1.2
MCCOOK COUNTY	1,594	24.7	1,183	18.4	636	9.9	381	5.9	166	2.6
MCPHERSON COUNTY	1,087	27.0	812	20.2	448	11.1	289	7.2	75	1.9
MARSHALL COUNTY	1,335	24.7	1,018	18.8	556	10.3	360	6.7	102	1.9
MEADE COUNTY	2,342	11.3	1,705	8.2	1,050	5.1	494	2.4	161	0.8
MELLETTE COUNTY	331	14.7	260	11.6	156	6.9	81	3.6	23	1.0
MINER COUNTY	1,081	28.9	822	22.0	448	12.0	258	6.9	116	3.1
MINNEHAHA COUNTY	16,021	14.6	11,596	10.6	6,392	5.8	3,822	3.5	1,382	1.3
MOODY COUNTY	1,501	22.4	1,106	16.5	609	9.1	377	5.6	120	1.8
PENNINGTON COUNTY	8,274	11.8	5,921	8.4	3,654	5.2	1,715	2.4	552	0.8
PERKINS COUNTY	1,015	21.5	712	15.1	438	9.3	215	4.6	59	1.3
POTTER COUNTY	847	23.1	648	17.6	346	9.4	222	6.0	80	2.2
ROBERTS COUNTY	2,498	22.9	1,957	17.9	1,067	9.8	678	6.2	212	1.9
SANBORN COUNTY	768	23.9	586	18.2	320	10.0	202	6.3	64	2.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
SHANNON COUNTY	818	7.2	575	5.1	344	3.0	188	1.7	43	0.4
SPINK COUNTY	2,008	21.8	1,498	16.3	793	8.6	502	5.5	203	2.2
STANLEY COUNTY	351	13.9	250	9.9	176	6.9	60	2.4	14	0.6
SULLY COUNTY	350	17.6	264	13.3	152	7.6	90	4.5	22	1.1
TODD COUNTY	564	7.7	383	5.2	239	3.3	111	1.5	33	0.5
TRIPP COUNTY	1,465	20.2	1,067	14.7	632	8.7	309	4.3	126	1.7
TURNER COUNTY	2,505	27.1	1,947	21.0	1,050	11.3	675	7.3	222	2.4
UNION COUNTY	2,069	18.9	1,560	14.3	840	7.7	539	4.9	181	1.7
WALWORTH COUNTY	1,599	22.8	1,253	17.9	668	9.5	432	6.2	153	2.2
YANKTON COUNTY	3,445	18.2	2,542	13.4	1,437	7.6	865	4.6	240	1.3
ZIEBACH COUNTY	211	9.1	143	6.2	87	3.8	45	1.9	11	0.5
TENNESSEE	717,361	15.6	517,588	11.3	323,027	7.0	153,118	3.3	41,443	0.9
ANDERSON COUNTY	10,944	16.3	7,433	11.0	5,055	7.5	1,888	2.8	490	0.7
BEDFORD COUNTY	5,421	19.4	3,941	14.1	2,405	8.6	1,207	4.3	329	1.2
BENTON COUNTY	3,288	22.1	2,472	16.6	1,533	10.3	733	4.9	206	1.4
BLEDSOE COUNTY	1,421	15.0	1,037	10.9	666	7.0	285	3.0	86	0.9
BLOUNT COUNTY	13,109	16.9	9,115	11.7	5,925	7.6	2,505	3.2	685	0.9
BRADLEY COUNTY	8,580	12.7	6,084	9.0	4,009	5.9	1,666	2.5	409	0.6
CAMPBELL COUNTY	6,245	17.9	4,478	12.8	2,859	8.2	1,333	3.8	286	0.8
CANNON COUNTY	1,990	19.4	1,449	14.2	898	8.8	441	4.3	110	1.1
CARROLL COUNTY	6,085	21.5	4,525	16.0	2,772	9.8	1,392	4.9	361	1.3
CARTER COUNTY	8,689	17.3	6,247	12.4	4,083	8.1	1,719	3.4	445	0.9
CHEATHAM COUNTY	2,654	12.3	1,891	8.7	1,208	5.6	545	2.5	138	0.6
CHESTER COUNTY	2,239	17.6	1,646	12.9	1,010	7.9	490	3.9	146	1.1
CLAIBORNE COUNTY	3,808	15.5	2,746	11.2	1,750	7.1	822	3.3	174	0.7
CLAY COUNTY	1,529	19.9	1,108	14.4	699	9.1	327	4.3	82	1.1
COCKE COUNTY	4,425	15.4	3,170	11.0	2,096	7.3	857	3.0	217	0.8
COFFEE COUNTY	6,058	15.8	4,303	11.2	2,689	7.0	1,245	3.2	369	1.0
CROCKETT COUNTY	3,236	21.7	2,425	16.2	1,522	10.2	716	4.8	187	1.3
CUMBERLAND COUNTY	5,117	17.8	3,676	12.8	2,381	8.3	1,015	3.5	280	1.0
DAVIDSON COUNTY	73,389	15.4	52,965	11.1	32,654	6.8	15,886	3.3	4,425	0.9
DECATUR COUNTY	2,369	21.8	1,756	16.2	1,081	10.0	540	5.0	135	1.2
DE KALB COUNTY	2,716	20.0	2,004	14.7	1,257	9.3	566	4.2	181	1.3
DICKSON COUNTY	5,172	17.2	3,816	12.7	2,398	8.0	1,108	3.7	310	1.0
DYER COUNTY	6,441	18.6	4,864	14.0	3,061	8.8	1,441	4.2	362	1.0
FAYETTE COUNTY	4,280	16.9	3,227	12.8	2,025	8.0	906	3.6	296	1.2
FENTRESS COUNTY	2,501	16.9	1,822	12.3	1,173	7.9	524	3.5	125	0.8
FRANKLIN COUNTY	5,327	16.7	3,848	12.0	2,497	7.8	1,103	3.4	248	0.8
GIBSON COUNTY	10,781	21.8	8,098	16.4	4,958	10.0	2,477	5.0	663	1.3
GILES COUNTY	5,079	20.6	3,732	15.2	2,283	9.3	1,120	4.5	329	1.3
GRAINGER COUNTY	2,717	16.2	1,945	11.6	1,240	7.4	588	3.5	117	0.7
GREENE COUNTY	8,844	16.3	6,241	11.5	3,966	7.3	1,831	3.4	444	0.8
GRUNDY COUNTY	2,090	15.2	1,537	11.1	959	7.0	459	3.3	119	0.9
HAMBLEN COUNTY	6,491	13.2	4,490	9.1	2,927	5.9	1,275	2.6	288	0.6
HAMILTON COUNTY	44,734	15.5	32,250	11.2	19,934	6.9	9,602	3.3	2,714	0.9
HANCOCK COUNTY	1,247	18.1	898	13.0	589	8.6	258	3.7	51	0.7
HARDEMAN COUNTY	4,478	18.8	3,361	14.1	1,996	8.4	1,050	4.4	315	1.3
HARDIN COUNTY	4,131	18.5	3,037	13.6	1,891	8.5	930	4.2	216	1.0
HAWKINS COUNTY	6,543	15.0	4,659	10.6	3,085	7.1	1,248	2.9	326	0.7
HAYWOOD COUNTY	3,935	19.4	2,978	14.7	1,801	8.9	887	4.4	290	1.4
HENDERSON COUNTY	3,920	18.3	2,903	13.6	1,766	8.3	886	4.1	251	1.2
HENRY COUNTY	6,596	23.0	4,949	17.3	3,109	10.8	1,408	4.9	432	1.5
HICKMAN COUNTY	2,591	17.1	1,839	12.1	1,173	7.7	506	3.3	160	1.1
HOUSTON COUNTY	1,359	19.8	1,017	14.8	641	9.3	303	4.4	73	1.1
HUMPHREYS COUNTY	2,691	16.9	1,989	12.5	1,256	7.9	594	3.7	139	0.9
JACKSON COUNTY	1,931	20.5	1,421	15.1	905	9.6	420	4.5	96	1.0
JEFFERSON COUNTY	5,026	16.1	3,577	11.4	2,242	7.2	1,061	3.4	274	0.9

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
JOHNSON COUNTY	2,477	18.0	1,817	13.2	1,147	8.3	530	3.8	140	1.0
KNOX COUNTY	49,426	15.5	35,757	11.2	21,782	6.8	11,037	3.5	2,938	0.9
LAKE COUNTY	1,519	20.4	1,125	15.1	680	9.1	335	4.5	110	1.5
LAUDERDALE COUNTY	4,660	19.0	3,464	14.1	2,163	8.8	1,036	4.2	265	1.1
LAWRENCE COUNTY	6,148	18.0	4,418	13.0	2,717	8.0	1,320	3.9	381	1.1
LEWIS COUNTY	1,520	15.7	1,136	11.7	747	7.7	311	3.2	78	0.8
LINCOLN COUNTY	5,074	19.2	3,649	13.8	2,306	8.7	1,094	4.1	249	0.9
LOUDON COUNTY	5,229	18.3	3,763	13.2	2,392	8.4	1,069	3.7	302	1.1
MCMINN COUNTY	6,915	16.5	5,000	11.9	3,021	7.2	1,615	3.9	364	0.9
MCNAIRY COUNTY	4,322	19.2	3,201	14.2	1,968	8.7	981	4.4	252	1.1
MACON COUNTY	2,892	18.4	2,126	13.5	1,227	7.8	718	4.6	181	1.2
MADISON COUNTY	13,024	17.5	9,738	13.1	5,829	7.8	3,043	4.1	866	1.2
MARION COUNTY	3,752	15.4	2,762	11.3	1,802	7.4	779	3.2	181	0.7
MARSHALL COUNTY	4,062	20.6	3,016	15.3	1,810	9.2	923	4.7	283	1.4
MAURY COUNTY	8,919	17.5	6,499	12.7	4,062	7.9	1,887	3.7	550	1.1
MEIGS COUNTY	1,034	13.9	682	9.2	463	6.2	182	2.4	37	0.5
MONROE COUNTY	4,609	16.1	3,323	11.6	2,094	7.3	974	3.4	255	0.9
MONTGOMERY COUNTY	8,746	10.5	6,324	7.6	3,927	4.7	1,849	2.2	548	0.7
MOORE COUNTY	740	16.4	535	11.9	362	8.0	149	3.3	24	0.5
MORGAN COUNTY	2,535	15.3	1,835	11.1	1,177	7.1	524	3.2	134	0.8
OBION COUNTY	6,589	20.1	4,904	15.0	2,990	9.1	1,521	4.C	393	1.2
OVERTON COUNTY	3,181	18.1	2,340	13.3	1,462	8.3	702	4.0	176	1.0
PERRY COUNTY	1,257	20.6	948	15.5	614	10.0	262	4.3	72	1.2
PICKETT COUNTY	890	20.4	664	15.2	406	9.3	208	4.8	50	1.1
POLK COUNTY	2,124	15.6	1,499	11.0	999	7.3	409	3.0	91	0.7
PUTNAM COUNTY	7,430	15.6	5,437	11.4	3,333	7.0	1,615	3.4	489	1.0
RHEA COUNTY	3,756	15.5	2,721	11.2	1,749	7.2	795	3.3	177	0.7
ROANE COUNTY	7,529	15.5	5,246	10.8	3,291	6.8	1,557	3.2	398	0.8
ROBERTSON COUNTY	6,190	16.7	4,574	12.4	2,776	7.5	1,395	3.8	403	1.1
RUTHERFORD COUNTY	10,027	11.9	7,115	8.5	4,357	5.2	2,141	2.5	617	0.7
SCOTT COUNTY	2,813	14.6	2,063	10.7	1,289	6.7	629	3.3	145	0.8
SEQUATCHIE COUNTY	1,267	14.7	923	10.7	575	6.7	270	3.1	78	0.9
SEVIER COUNTY	6,373	15.4	4,548	11.0	2,879	7.0	1,320	3.2	349	0.8
SHELBY COUNTY	102,366	13.2	72,878	9.4	45,025	5.8	21,770	2.8	6,083	0.8
SMITH COUNTY	2,985	20.0	2,200	14.7	1,344	9.0	690	4.6	166	1.1
STEWART COUNTY	1,834	21.2	1,380	15.9	897	10.4	370	4.3	113	1.3
SULLIVAN COUNTY	21,714	15.1	15,054	10.5	9,802	6.8	4,204	2.9	1,048	0.7
SUMNER COUNTY	10,786	12.6	7,541	8.8	4,790	5.6	2,196	2.6	555	0.6
TIPTON COUNTY	5,034	15.3	3,728	11.3	2,421	7.4	1,030	3.1	277	0.8
TROUSDALE COUNTY	1,097	17.9	794	12.9	495	8.1	239	3.9	60	1.0
UNICOI COUNTY	3,067	18.7	2,208	13.5	1,318	8.1	702	4.3	188	1.1
UNION COUNTY	1,733	14.8	1,252	10.7	797	6.8	378	3.2	77	0.7
VAN BUREN COUNTY	692	14.6	484	10.2	305	6.5	136	2.9	43	0.9
WARREN COUNTY	5,558	17.0	4,036	12.4	2,479	7.6	1,225	3.8	332	1.0
WASHINGTON COUNTY	13,670	15.4	9,846	11.1	6,035	6.8	2,940	3.3	871	1.0
WAYNE COUNTY	2,381	17.1	1,722	12.3	1,077	7.7	525	3.8	120	0.9
WEAKLEY COUNTY	6,629	20.2	5,019	15.3	2,960	9.0	1,619	4.9	440	1.3
WHITE COUNTY	3,827	19.6	2,812	14.4	1,796	9.2	806	4.1	210	1.1
WILLIAMSON COUNTY	6,919	11.9	4,951	8.5	3,116	5.4	1,403	2.4	432	0.7
WILSON COUNTY	7,822	14.0	5,562	9.9	3,547	6.3	1,542	2.8	473	0.8
TEXAS	1,902,710	13.4	1,371,161	9.6	847,265	6.0	411,874	2.9	112,022	0.8
ANDERSON COUNTY	7,698	20.1	5,833	15.2	3,468	9.0	1,830	4.8	535	1.4
ANDREWS COUNTY	1,486	11.2	1,004	7.5	682	5.1	263	2.0	59	0.4
ANGELINA COUNTY	10,219	15.9	7,462	11.6	4,690	7.3	2,221	3.5	551	0.9
ARANSAS COUNTY	3,127	21.9	2,160	15.1	1,500	10.5	547	3.8	113	0.8
ARCHER COUNTY	1,361	18.7	1,007	13.9	607	8.4	324	4.5	76	1.0
ARMSTRONG COUNTY	507	25.4	377	18.9	217	10.9	120	6.0	40	2.0

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ATASCOSA COUNTY	4,069	16.2	2,996	12.0	1,881	7.5	889	3.5	226	0.9
AUSTIN COUNTY	4,243	23.9	3,329	18.8	1,896	10.7	1,097	6.2	336	1.9
BAILEY COUNTY	1,321	16.2	973	11.9	627	7.7	282	3.5	64	0.8
BANDERA COUNTY	1,794	25.3	1,311	18.5	839	11.8	371	5.2	101	1.4
BASTROP COUNTY	5,228	21.1	4,001	16.2	2,411	9.8	1,236	5.0	354	1.4
BAYLOR COUNTY	1,470	29.9	1,154	23.5	682	13.9	391	7.9	81	1.6
BEE COUNTY	3,510	13.5	2,632	10.1	1,564	6.0	844	3.2	224	0.9
BELL COUNTY	17,315	11.0	12,395	7.9	7,446	4.7	3,739	2.4	1,210	0.8
BEXAR COUNTY	121,635	12.3	85,925	8.7	52,601	5.3	25,947	2.6	7,377	0.7
BLANCO COUNTY	1,288	27.5	944	20.2	552	11.8	289	6.2	103	2.2
BORDEN COUNTY	129	15.0	92	10.7	57	6.6	29	3.4	6	0.7
BOSQUE COUNTY	4,575	34.1	3,546	26.5	2,114	15.8	1,110	8.3	322	2.4
BOWIE COUNTY	13,643	18.1	10,009	13.3	6,119	8.1	3,073	4.1	817	1.1
BRAZORIA COUNTY	15,284	9.0	10,263	6.1	6,748	4.0	2,771	1.6	744	0.4
BRAZOS COUNTY	8,701	9.3	6,388	6.8	3,826	4.1	1,940	2.1	622	0.7
BREWSTER COUNTY	1,206	15.9	867	11.4	498	6.6	273	3.6	96	1.3
BRISCOE COUNTY	595	23.1	435	16.9	281	10.9	127	4.9	27	1.0
BROOKS COUNTY	1,415	16.8	1,029	12.2	661	7.8	296	3.5	72	0.9
BROWN COUNTY	7,390	22.4	5,728	17.3	3,350	10.1	1,797	5.4	581	1.8
BURLESON COUNTY	3,050	24.8	2,308	18.7	1,317	10.7	776	6.3	215	1.7
BURNET COUNTY	5,415	30.4	4,049	22.7	2,692	15.1	1,125	6.3	232	1.3
CALDWELL COUNTY	4,427	18.7	3,415	14.4	1,893	8.0	1,159	4.9	363	1.5
CALHOUN COUNTY	2,338	11.9	1,568	8.0	1,039	5.3	432	2.2	97	0.5
CALLAHAN COUNTY	2,702	24.6	2,121	19.3	1,220	11.1	722	6.6	179	1.6
CAMERON COUNTY	27,332	13.0	20,092	9.6	13,075	6.2	5,690	2.7	1,327	0.6
CAMP COUNTY	2,058	22.2	1,509	16.3	898	9.7	475	5.1	136	1.5
CARSON COUNTY	1,232	18.5	893	13.4	549	8.2	276	4.1	68	1.0
CASS COUNTY	6,218	21.1	4,689	15.9	2,846	9.7	1,427	4.8	416	1.4
CASTRO COUNTY	1,160	11.0	817	7.7	532	5.0	219	2.1	66	0.6
CHAMBERS COUNTY	2,164	11.7	1,473	7.9	1,026	5.5	351	1.9	96	0.5
CHEROKEE COUNTY	8,817	23.1	6,723	17.6	4,064	10.7	2,071	5.4	588	1.5
CHILDRESS COUNTY	1,939	27.9	1,550	22.3	887	12.8	510	7.3	153	2.2
CLAY COUNTY	2,217	23.1	1,711	17.9	997	10.4	553	5.8	161	1.7
COCHRAN COUNTY	709	14.7	514	10.7	332	6.9	149	3.1	33	0.7
COKE COUNTY	982	30.7	765	23.9	442	13.8	246	7.7	77	2.4
COLEMAN COUNTY	3,350	32.1	2,669	25.6	1,481	14.2	908	8.7	280	2.7
COLLIN COUNTY	12,949	9.0	9,499	6.6	5,609	3.9	3,041	2.1	849	0.6
COLLINGSWORTH COUNTY	1,244	26.8	995	21.4	550	11.8	337	7.3	108	2.3
COLORADO COUNTY	4,334	23.0	3,298	17.5	1,943	10.3	1,001	5.3	354	1.9
COMAL COUNTY	7,454	20.5	5,399	14.8	3,372	9.3	1,544	4.2	483	1.3
COMANCHE COUNTY	3,789	30.0	2,997	23.8	1,766	14.0	960	7.6	271	2.1
CONCHO COUNTY	832	28.5	636	21.8	361	12.4	220	7.5	55	1.9
COOKE COUNTY	5,401	19.5	4,003	14.5	2,511	9.1	1,170	4.2	322	1.2
CORYELL COUNTY	4,151	7.3	3,137	5.5	1,768	3.1	1,068	1.9	301	0.5
COTTLE COUNTY	826	28.0	667	22.6	378	12.8	229	7.8	60	2.0
CRANE COUNTY	593	12.9	368	8.0	246	5.3	105	2.3	17	0.4
CROCKETT COUNTY	612	13.3	427	9.3	270	5.9	129	2.8	28	0.6
CROSBY COUNTY	1,628	18.4	1,249	14.1	754	8.5	376	4.2	119	1.3
CULBERSON COUNTY	339	10.2	237	7.1	163	4.9	59	1.8	15	0.5
DALLAM COUNTY	1,081	16.6	817	12.5	512	7.8	242	3.7	63	1.0
DALLAS COUNTY	174,304	11.2	121,523	7.8	75,484	4.8	36,093	2.3	9,946	0.6
DAWSON COUNTY	2,841	17.6	2,113	13.1	1,272	7.9	663	4.1	178	1.1
DEAF SMITH COUNTY	2,475	11.7	1,802	8.5	1,113	5.3	527	2.5	162	0.8
DELTA COUNTY	1,628	33.6	1,279	26.4	738	15.3	400	8.3	141	2.9
DENTON COUNTY	12,875	9.0	9,222	6.4	5,695	4.0	2,753	1.9	774	0.5
DE WITT COUNTY	5,142	27.2	3,992	21.1	2,149	11.4	1,418	7.5	425	2.2
DICKENS COUNTY	1,003	28.3	798	22.5	477	13.5	257	7.3	64	1.8

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
DIMMIT COUNTY	1,495	13.2	1,134	10.0	672	5.9	352	3.1	110	1.0
DONLEY COUNTY	1,163	28.5	888	21.8	519	12.7	294	7.2	75	1.8
DUVAL COUNTY	2,293	18.3	1,743	13.9	1,066	8.5	563	4.5	114	0.9
EASTLAND COUNTY	5,705	29.3	4,514	23.2	2,516	12.9	1,543	7.9	455	2.3
ECTOR COUNTY	12,012	10.4	8,021	7.0	5,454	4.7	2,132	1.8	435	0.4
EDWARDS COUNTY	372	18.3	300	14.8	193	9.5	94	4.6	13	0.6
ELLIS COUNTY	10,200	17.1	7,764	13.0	4,535	7.6	2,470	4.1	759	1.3
EL PASO COUNTY	46,406	9.7	31,645	6.6	20,091	4.2	9,152	1.9	2,402	0.5
ERATH COUNTY	5,578	24.7	4,456	19.8	2,466	10.9	1,523	6.8	467	2.1
FALLS COUNTY	5,228	29.1	4,126	23.0	2,349	13.1	1,358	7.6	419	2.3
FANNIN COUNTY	6,969	28.7	5,419	22.3	3,169	13.0	1,732	7.1	518	2.1
FAYETTE COUNTY	5,819	30.9	4,463	23.7	2,626	13.9	1,450	7.7	387	2.1
FISHER COUNTY	1,589	27.0	1,238	21.0	722	12.3	420	7.1	96	1.6
FLOYD COUNTY	1,908	19.4	1,430	14.5	845	8.6	448	4.6	137	1.4
FOARD COUNTY	687	31.8	547	25.3	318	14.7	177	8.2	52	2.4
FORT BEND COUNTY	9,437	7.2	6,487	5.0	4,082	3.1	1,846	1.4	559	0.4
FRANKLIN COUNTY	1,756	25.5	1,346	19.5	769	11.2	424	6.2	153	2.2
FREESTONE COUNTY	3,895	26.3	3,064	20.7	1,811	12.2	959	6.5	294	2.0
FRIO COUNTY	1,943	14.1	1,444	10.5	829	6.0	455	3.3	160	1.2
GAINES COUNTY	1,669	12.7	1,193	9.1	799	6.1	341	2.6	53	0.4
GALVESTON COUNTY	25,970	13.3	17,770	9.1	11,473	5.9	5,014	2.6	1,283	0.7
GARZA COUNTY	1,010	18.9	737	13.8	479	9.0	212	4.0	46	0.9
GILLESPIE COUNTY	3,966	29.3	3,066	22.7	1,717	12.7	1,022	7.6	327	2.4
GLASSCOCK COUNTY	144	11.0	100	7.7	79	6.1	19	1.5	2	0.2
GOLIAD COUNTY	1,082	20.8	798	15.4	471	9.1	252	4.9	75	1.4
GONZALES COUNTY	3,927	23.3	3,054	18.1	1,679	9.9	1,026	6.1	349	2.1
GRAY COUNTY	5,281	20.0	3,961	15.0	2,484	9.4	1,197	4.5	280	1.1
GRAYSON COUNTY	18,525	20.6	13,984	15.6	8,167	9.1	4,493	5.0	1,324	1.5
GREGG COUNTY	15,330	15.4	11,315	11.4	6,972	7.0	3,469	3.5	874	0.9
GRIMES COUNTY	3,160	23.3	2,442	18.0	1,421	10.5	794	5.8	227	1.7
GUADALUPE COUNTY	7,419	15.9	5,361	11.5	3,214	6.9	1,648	3.5	499	1.1
HALE COUNTY	5,919	15.7	4,359	11.6	2,650	7.0	1,316	3.5	393	1.0
HALL COUNTY	1,538	27.5	1,223	21.9	706	12.6	389	7.0	128	2.3
HAMILTON COUNTY	2,948	35.5	2,342	28.2	1,321	15.9	762	9.2	259	3.1
HANSFORD COUNTY	864	13.9	610	9.8	379	6.1	191	3.1	40	0.6
HARDEMAN COUNTY	1,797	28.2	1,395	21.9	818	12.8	447	7.0	130	2.0
HARDIN COUNTY	5,891	14.5	4,208	10.3	2,721	6.7	1,230	3.0	258	0.6
HARRIS COUNTY	217,420	9.0	147,081	6.1	94,650	3.9	41,993	1.7	10,438	0.4
HARRISON COUNTY	9,600	18.4	7,204	13.8	4,224	8.1	2,296	4.4	684	1.3
HARTLEY COUNTY	722	18.1	533	13.4	326	8.2	146	3.7	61	1.5
HASKELL COUNTY	2,267	29.3	1,757	22.7	1,047	13.6	559	7.2	151	2.0
HAYS COUNTY	4,460	11.0	3,290	8.1	2,041	5.0	948	2.3	301	0.7
HEMPHILL COUNTY	690	13.0	493	9.3	293	5.5	158	3.0	42	0.8
HENDERSON COUNTY	10,238	24.0	7,294	17.1	4,979	11.7	1,862	4.4	453	1.1
HIDALGO COUNTY	35,330	12.5	26,075	9.2	16,890	6.0	7,424	2.6	1,761	0.6
HILL COUNTY	7,145	28.6	5,513	22.0	3,341	13.4	1,668	6.7	504	2.0
HOCKLEY COUNTY	3,172	13.7	2,287	9.8	1,529	6.6	616	2.7	142	0.6
HOOD COUNTY	3,748	21.2	2,550	14.4	1,682	9.5	676	3.8	192	1.1
HOPKINS COUNTY	5,833	23.1	4,460	17.7	2,671	10.6	1,416	5.6	373	1.5
HOUSTON COUNTY	5,124	23.0	3,967	17.8	2,333	10.5	1,264	5.7	370	1.7
HOWARD COUNTY	5,724	17.3	4,092	12.3	2,632	7.9	1,231	3.7	229	0.7
HUDSPETH COUNTY	300	11.0	224	8.2	151	5.5	63	2.3	10	0.4
HUNT COUNTY	10,787	19.5	8,084	14.6	4,883	8.8	2,496	4.5	705	1.3
HUTCHINSON COUNTY	4,760	18.1	3,261	12.4	2,254	8.6	831	3.2	176	0.7
IRION COUNTY	294	21.2	217	15.7	157	11.3	47	3.4	13	0.9
JACK COUNTY	1,832	24.7	1,418	19.1	810	10.9	475	6.4	133	1.8
JACKSON COUNTY	2,529	18.9	1,847	13.8	1,217	9.1	501	3.8	129	1.0

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
JASPER COUNTY	5,754	18.7	4,243	13.8	2,620	8.5	1,318	4.3	305	1.0
JEFF DAVIS COUNTY	328	19.9	240	14.6	159	9.7	60	3.6	21	1.3
JEFFERSON COUNTY	39,306	15.7	28,061	11.2	17,627	7.0	8,401	3.3	2,033	0.8
JIM HOGG COUNTY	874	16.9	667	12.9	431	8.3	198	3.8	38	0.7
JIM WELLS COUNTY	5,044	13.8	3,684	10.1	2,479	6.8	971	2.7	234	0.6
JOHNSON COUNTY	10,608	15.7	7,944	11.7	4,562	6.7	2,571	3.8	811	1.2
JONES COUNTY	4,242	24.6	3,257	18.9	1,886	10.9	1,087	6.3	284	1.6
KARNES COUNTY	2,781	20.5	2,089	15.4	1,244	9.2	674	5.0	171	1.3
KAUFMAN COUNTY	7,295	18.7	5,493	14.1	3,225	8.3	1,726	4.4	542	1.4
KENDALL COUNTY	2,299	21.6	1,702	16.0	944	8.9	547	5.1	211	2.0
KENEDY COUNTY	87	16.0	70	12.9	32	5.9	34	6.3	4	0.7
KENT COUNTY	310	27.1	226	19.7	153	13.4	59	5.2	14	1.2
KERR COUNTY	8,848	30.7	6,836	23.8	4,190	14.6	2,075	7.2	571	2.0
KIMBLE COUNTY	1,034	25.4	801	19.7	445	11.0	265	6.5	91	2.2
KING COUNTY	57	13.4	36	8.5	22	5.2	12	2.8	2	0.5
KINNEY COUNTY	464	20.4	328	14.4	226	9.9	79	3.5	23	1.0
KLEBERG COUNTY	3,446	10.3	2,493	7.5	1,568	4.7	755	2.3	170	0.5
KNOX COUNTY	1,545	29.0	1,187	22.3	668	12.5	393	7.4	126	2.4
LAMAR COUNTY	9,338	22.2	7,115	16.9	4,167	9.9	2,266	5.4	682	1.6
LAMB COUNTY	3,718	19.9	2,749	14.7	1,740	9.3	806	4.3	203	1.1
LAMPASAS COUNTY	2,547	21.2	1,971	16.4	1,139	9.5	613	5.1	219	1.8
LA SALLE COUNTY	884	16.0	650	11.8	423	7.7	190	3.4	37	0.7
LAVACA COUNTY	5,525	29.1	4,273	22.5	2,443	12.9	1,378	7.3	452	2.4
LEE COUNTY	2,486	22.7	1,927	17.6	1,165	10.6	583	5.3	179	1.6
LEON COUNTY	2,956	30.8	2,274	23.7	1,397	14.6	689	7.2	188	2.0
LIBERTY COUNTY	7,261	15.4	5,151	10.9	3,293	7.0	1,420	3.0	438	0.9
LIMESTONE COUNTY	5,588	27.6	4,374	21.6	2,532	12.5	1,420	7.0	422	2.1
LIPSCOMB COUNTY	681	18.1	493	13.1	308	8.2	158	4.2	27	0.7
LIVE OAK COUNTY	1,769	18.4	1,288	13.4	875	9.1	343	3.6	70	0.7
LLANO COUNTY	4,266	42.1	3,179	31.3	2,162	21.3	826	8.1	191	1.9
LOVING COUNTY	25	27.5	16	17.6	10	11.0	5	5.5	1	1.1
LUBBOCK COUNTY	23,367	11.0	16,664	7.9	10,539	5.0	4,901	2.3	1,224	0.6
LYNN COUNTY	1,532	17.8	1,152	13.4	703	8.2	362	4.2	87	1.0
MCCULLOCH COUNTY	2,633	30.1	2,156	24.7	1,186	13.6	747	8.6	223	2.6
MCLENNAN COUNTY	30,415	17.8	22,534	13.2	13,417	7.9	7,076	4.1	2,041	1.2
MCMULLEN COUNTY	173	21.9	127	16.1	95	12.0	28	3.5	4	0.5
MADISON COUNTY	2,181	20.5	1,694	15.9	1,030	9.7	500	4.7	164	1.5
MARION COUNTY	2,516	24.3	1,850	17.9	1,147	11.1	551	5.3	152	1.5
MARTIN COUNTY	783	16.7	579	12.4	348	7.4	177	3.8	54	1.2
MASON COUNTY	1,107	30.1	882	23.9	470	12.8	292	7.9	120	3.3
MATAGORDA COUNTY	5,419	14.3	3,916	10.4	2,423	6.4	1,187	3.1	306	0.8
MAVERICK COUNTY	3,013	9.6	2,136	6.8	1,444	4.6	582	1.9	110	0.4
MEDINA COUNTY	4,165	18.0	3,112	13.4	1,776	7.7	1,027	4.4	309	1.3
MENARD COUNTY	680	29.0	539	23.0	312	13.3	175	7.5	52	2.2
MIDLAND COUNTY	9,141	11.1	6,081	7.4	4,016	4.9	1,648	2.0	417	0.5
MILAM COUNTY	5,352	23.5	4,158	18.3	2,376	10.5	1,359	6.0	423	1.9
MILLS COUNTY	1,558	34.8	1,237	27.6	730	16.3	382	8.5	125	2.8
MITCHELL COUNTY	2,279	25.1	1,756	19.3	1,055	11.6	536	5.9	165	1.8
MONTAGUE COUNTY	4,919	28.3	3,821	21.9	2,169	12.5	1,251	7.2	401	2.3
MONTGOMERY COUNTY	13,117	10.2	9,056	7.0	6,136	4.8	2,394	1.9	526	0.4
MOORE COUNTY	1,932	11.7	1,257	7.6	892	5.4	299	1.8	66	0.4
MORRIS COUNTY	2,715	18.6	2,024	13.8	1,249	8.5	607	4.1	168	1.1
MOTLEY COUNTY	588	30.2	470	24.1	273	14.0	173	8.9	24	1.2
NACOGDOCHES COUNTY	7,470	16.0	5,635	12.0	3,366	7.2	1,761	3.8	508	1.1
NAVARRO COUNTY	8,771	24.8	6,910	19.6	4,019	11.4	2,197	6.2	694	2.0
NEWTON COUNTY	2,379	17.9	1,779	13.4	1,181	8.9	488	3.7	110	0.8
NOLAN COUNTY	3,628	20.9	2,811	16.2	1,667	9.6	927	5.3	217	1.3

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
NUECES COUNTY	31,829	11.9	22,264	8.3	14,534	5.4	6,219	2.3	1,511	0.6
OCHILTREE COUNTY	1,222	12.7	870	9.1	542	5.7	249	2.6	79	0.8
OLDHAM COUNTY	283	12.4	194	8.5	141	6.2	47	2.1	6	0.3
ORANGE COUNTY	9,464	11.3	6,327	7.5	4,196	5.0	1,700	2.0	431	0.5
PALO PINTO COUNTY	5,177	21.5	3,833	15.9	2,406	10.0	1,122	4.7	305	1.3
PANOLA COUNTY	4,383	21.1	3,286	15.9	1,993	9.6	1,027	5.0	266	1.3
PARKER COUNTY	7,349	16.5	5,309	11.9	3,238	7.3	1,605	3.6	466	1.0
PARMER COUNTY	1,507	13.7	1,065	9.6	666	6.0	302	2.7	97	0.9
PECOS COUNTY	1,549	10.6	1,059	7.2	690	4.7	300	2.1	69	0.5
POLK COUNTY	5,815	23.8	4,207	17.2	2,837	11.6	1,100	4.5	270	1.1
POTTER COUNTY	16,065	16.3	,681	11.8	7,243	7.3	3,523	3.6	915	0.9
PRESIDIO COUNTY	977	18.8	752	14.5	438	8.4	268	5.2	46	0.9
RAINS COUNTY	1,264	26.1	909	18.8	598	12.4	252	5.2	59	1.2
RANDALL COUNTY	7,845	10.5	5,229	7.0	3,370	4.5	1,516	2.0	343	0.5
REAGAN COUNTY	368	8.9	235	5.7	167	4.0	59	1.4	9	0.2
REAL COUNTY	573	23.2	402	16.3	258	10.4	121	4.9	23	0.9
RED RIVER COUNTY	4,256	26.4	3,323	20.6	1,865	11.6	1,104	6.9	354	2.2
REEVES COUNTY	1,861	11.8	1,276	8.1	825	5.2	369	2.3	82	0.5
REFUGIO COUNTY	1,728	18.6	1,247	13.4	824	8.9	343	3.7	80	0.9
ROBERTS COUNTY	201	16.9	151	12.7	93	7.8	51	4.3	7	0.6
ROBERTSON COUNTY	3,955	27.0	3,064	20.9	1,757	12.0	975	6.7	332	2.3
ROCKWALL COUNTY	1,766	12.2	1,246	8.6	732	5.0	375	2.6	139	1.0
RUNNELS COUNTY	3,204	27.0	2,470	20.8	1,447	12.2	804	6.8	219	1.8
RUSK COUNTY	9,508	23.0	7,362	17.8	4,286	10.4	2,458	5.9	618	1.5
SABINE COUNTY	2,336	26.8	1,724	19.8	1,121	12.9	493	5.7	110	1.3
SAN AUGUSTINE COUNTY	2,262	25.7	1,706	19.4	1,079	12.3	506	5.8	121	1.4
SAN JACINTO COUNTY	2,334	20.4	1,668	14.6	1,122	9.8	449	3.9	97	0.8
SAN PATRICIO COUNTY	6,901	11.9	4,978	8.6	3,189	5.5	1,419	2.4	370	0.6
SAN SABA COUNTY	1,867	30.1	1,456	23.5	820	13.2	468	7.5	168	2.7
SCHLEICHER COUNTY	508	18.0	380	13.5	222	7.9	136	4.8	22	0.8
SCURRY COUNTY	3,036	16.7	2,218	12.2	1,379	7.6	668	3.7	171	0.9
SHACKELFORD COUNTY	970	24.8	777	19.8	445	11.4	254	6.5	78	2.0
SHELBY COUNTY	5,615	24.3	4,280	18.5	2,594	11.2	1,324	5.7	362	1.6
SHERMAN COUNTY	529	16.7	386	12.2	217	6.8	138	4.3	31	1.0
SMITH COUNTY	21,879	17.0	16,049	12.5	9,920	7.7	4,837	3.8	1,292	1.0
SOMERVELL COUNTY	757	18.2	595	14.3	337	8.1	194	4.7	64	1.5
STARR COUNTY	3,264	12.0	2,437	8.9	1,469	5.4	753	2.8	215	0.8
STEPHENS COUNTY	2,247	22.6	1,700	17.1	1,017	10.2	545	5.5	138	1.4
STERLING COUNTY	236	19.6	176	14.6	94	7.8	62	5.1	20	1.7
STONEWALL COUNTY	670	27.8	531	22.1	354	14.7	136	5.7	41	1.7
SUTTON COUNTY	551	10.7	389	7.6	210	4.1	135	2.6	44	0.9
SWISHER COUNTY	1,717	17.7	1,256	12.9	768	7.9	390	4.0	98	1.0
TARRANT COUNTY	104,735	12.2	73,050	8.5	44,893	5.2	22,061	2.6	6,096	0.7
TAYLOR COUNTY	16,048	14.5	11,833	10.7	6,936	6.3	3,801	3.4	1,096	1.0
TERRELL COUNTY	282	17.7	208	13.0	122	7.6	69	4.3	17	1.1
TERRY COUNTY	2,276	15.6	1,703	11.7	1,082	7.4	501	3.4	120	0.8
THROCKMORTON COUNTY	641	31.2	511	24.9	301	14.7	172	8.4	38	1.9
TITUS COUNTY	4,505	21.0	3,414	15.9	2,075	9.7	1,027	4.8	312	1.5
TOM GREEN COUNTY	13,853	16.3	10,253	12.1	6,216	7.3	3,208	3.8	829	1.0
TRAVIS COUNTY	43,161	10.3	30,671	7.3	18,939	4.5	9,025	2.2	2,707	0.6
TRINITY COUNTY	2,607	27.6	1,988	21.0	1,226	13.0	621	6.6	141	1.5
TYLER COUNTY	3,949	24.3	2,846	17.5	1,823	11.2	822	5.1	201	1.2
UPSHUR COUNTY	5,640	19.7	4,274	14.9	2,603	9.1	1,343	4.7	328	1.1
UPTON COUNTY	613	13.3	437	9.5	274	5.9	131	2.8	32	0.7
UVALDE COUNTY	3,508	15.6	2,651	11.8	1,574	7.0	822	3.7	255	1.1
VAL VERDE COUNTY	3,829	10.7	2,674	7.4	1,724	4.8	783	2.2	167	0.5
VAN ZANDT COUNTY	7,594	24.2	5,646	18.0	3,590	11.4	1,647	5.2	409	1.3

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
VICTORIA COUNTY	8,238	12.0	5,850	8.5	3,636	5.3	1,758	2.6	456	0.7
WALKER COUNTY	4,792	11.5	3,497	8.4	2,104	5.0	1,067	2.6	326	0.8
WALLER COUNTY	2,969	15.0	2,217	11.2	1,312	6.6	703	3.6	202	1.0
WARD COUNTY	1,800	12.9	1,303	9.3	868	6.2	376	2.7	59	0.4
WASHINGTON COUNTY	5,246	23.8	4,072	18.5	2,262	10.3	1,425	6.5	385	1.8
WEBB COUNTY	11,105	11.2	8,312	8.4	5,031	5.1	2,537	2.6	744	0.7
WHARTON COUNTY	7,261	18.0	5,430	13.5	3,320	8.3	1,654	4.1	456	1.1
WHEELER COUNTY	1,786	25.0	1,393	19.5	819	11.5	477	6.7	97	1.4
WICHITA COUNTY	18,415	15.2	13,645	11.3	7,918	6.5	4,479	3.7	1,248	1.0
WILBARGER COUNTY	4,063	25.5	3,164	19.9	1,813	11.4	1,056	6.6	295	1.9
WILLACY COUNTY	2,389	13.7	1,768	10.1	1,118	6.4	506	2.9	144	0.8
WILLIAMSON COUNTY	10,247	13.4	7,683	10.0	4,500	5.9	2,393	3.1	790	1.0
WILSON COUNTY	2,982	17.8	2,213	13.2	1,345	8.0	670	4.0	198	1.2
WINKLER COUNTY	1,439	14.5	1,012	10.2	676	6.8	283	2.8	53	0.5
WISE COUNTY	4,969	18.7	3,696	13.9	2,130	8.0	1,232	4.6	334	1.3
WOOD COUNTY	6,608	26.8	4,980	20.2	2,987	12.1	1,565	6.3	428	1.7
YOAKUM COUNTY	940	11.3	639	7.7	436	5.3	162	2.0	41	0.5
YOUNG COUNTY	4,541	23.8	3,554	18.6	2,031	10.6	1,207	6.3	316	1.7
ZAPATA COUNTY	1,441	21.7	1,048	15.8	730	11.0	276	4.2	42	0.6
ZAVALA COUNTY	1,521	13.0	1,127	9.7	764	6.5	299	2.6	64	0.5
UTAH	155,480	10.6	109,220	7.5	67,820	4.6	32,548	2.2	8,852	0.6
BEAVER COUNTY	868	19.8	615	14.0	365	8.3	203	4.6	47	1.1
BOX ELDER COUNTY	4,135	12.4	2,935	8.8	1,769	5.3	920	2.8	246	0.7
CACHE COUNTY	6,451	11.3	4,792	8.4	2,775	4.9	1,582	2.8	435	0.8
CARBON COUNTY	3,126	14.1	2,157	9.7	1,401	6.3	587	2.6	169	0.8
DAGGETT COUNTY	80	10.4	56	7.3	41	5.3	14	1.8	1	0.1
DAVIS COUNTY	10,127	6.9	6,506	4.4	4,179	2.8	1,789	1.2	538	0.4
DUCHESNE COUNTY	1,199	9.5	851	6.8	563	4.5	233	1.8	55	0.4
EMERY COUNTY	1,055	9.2	772	6.7	496	4.3	218	1.9	58	0.5
GARFIELD COUNTY	624	17.0	435	11.8	294	8.0	119	3.2	22	0.6
GRAND COUNTY	807	9.8	544	6.6	375	4.6	140	1.7	29	0.4
IRON COUNTY	1,891	10.9	1,286	7.4	818	4.7	380	2.2	88	0.5
JUAB COUNTY	951	17.2	703	12.7	456	8.2	199	3.6	48	0.9
KANE COUNTY	650	16.2	438	10.9	288	7.2	118	2.9	32	0.8
MILLARD COUNTY	1,506	16.8	1,132	12.6	687	7.7	360	4.0	85	0.9
MORGAN COUNTY	471	9.6	356	7.2	233	4.7	98	2.0	25	0.5
PIUTE COUNTY	313	23.6	220	16.6	154	11.6	54	4.1	12	0.9
RICH COUNTY	261	12.4	195	9.3	137	6.5	47	2.2	11	0.5
SALT LAKE COUNTY	66,246	10.7	46,532	7.5	28,456	4.6	14,136	2.3	3,940	0.6
SAN JUAN COUNTY	905	7.4	627	5.1	407	3.3	162	1.3	58	0.5
SANPETE COUNTY	2,573	17.6	1,932	13.2	1,222	8.4	563	3.9	147	1.0
SEVIER COUNTY	2,396	16.3	1,748	11.9	1,071	7.3	535	3.6	142	1.0
SUMMIT COUNTY	988	9.7	715	7.0	477	4.7	198	1.9	40	0.4
TOOELE COUNTY	2,495	9.6	1,580	6.1	1,016	3.9	475	1.8	89	0.3
UINTAH COUNTY	1,757	8.6	1,222	6.0	770	3.8	376	1.8	76	0.4
UTAH COUNTY	18,714	8.6	13,276	6.1	8,412	3.9	3,876	1.8	988	0.5
WASATCH COUNTY	1,084	12.7	779	9.1	486	5.7	231	2.7	62	0.7
WASHINGTON COUNTY	4,712	18.1	3,479	13.3	2,222	8.5	993	3.8	264	1.0
WAYNE COUNTY	369	19.3	260	13.6	167	8.7	76	4.0	17	0.9
WEBER COUNTY	18,726	12.9	13,077	9.0	8,083	5.6	3,866	2.7	1,128	0.8
VERMONT	79,189	15.5	58,166	11.4	33,773	6.6	18,386	3.6	6,007	1.2
ADDISON COUNTY	3,920	13.3	2,852	9.7	1,663	5.7	903	3.1	286	1.0
BENNINGTON COUNTY	6,161	18.5	4,691	14.1	2,726	8.2	1,472	4.4	493	1.5
CALEDONIA COUNTY	4,400	17.0	3,252	12.6	1,879	7.3	1,046	4.1	327	1.3
CHITTENDEN COUNTY	12,138	10.5	8,788	7.6	5,174	4.5	2,724	2.4	890	0.8
ESSEX COUNTY	1,095	17.3	782	12.4	480	7.6	253	4.0	49	0.8
FRANKLIN COUNTY	5,347	15.4	3,917	11.3	2,183	6.3	1,331	3.8	403	1.2

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
GRAND ISLE COUNTY	762	16.5	533	11.6	330	7.2	167	3.6	36	0.8
LAMOILLE COUNTY	2,406	14.3	1,773	10.6	1,067	6.4	545	3.3	161	1.0
ORANGE COUNTY	3,678	16.2	2,727	12.0	1,619	7.1	837	3.7	271	1.2
ORLEANS COUNTY	3,992	17.0	2,887	12.3	1,604	6.8	983	4.2	300	1.3
RUTLAND COUNTY	10,521	18.0	7,721	13.2	4,456	7.6	2,384	4.1	881	1.5
WASHINGTON COUNTY	8,743	16.7	6,529	12.5	3,792	7.2	2,073	4.0	664	1.3
WINDHAM COUNTY	6,572	17.8	4,889	13.2	2,771	7.5	1,606	4.3	512	1.4
WINDSOR COUNTY	9,454	18.5	6,825	13.4	4,029	7.9	2,062	4.0	734	1.4
VIRGINIA	726,370	13.6	505,304	9.5	318,296	6.0	145,677	2.7	41,131	0.8
ACCOMACK COUNTY	7,050	22.5	5,210	16.7	3,100	9.9	1,602	5.1	508	1.6
ALBEMARLE COUNTY	6,203	11.1	4,410	7.9	2,796	5.0	1,254	2.2	360	0.6
ALLEGHANY COUNTY	2,188	15.3	1,518	10.6	1,006	7.0	432	3.0	80	0.6
AMELIA COUNTY	1,443	17.2	1,050	12.5	644	7.7	330	3.9	76	0.9
AMHERST COUNTY	4,270	14.7	3,028	10.4	1,927	6.6	885	3.0	216	0.7
APPOMATTOX COUNTY	2,058	17.2	1,478	12.3	919	7.7	466	3.9	93	0.8
ARLINGTON COUNTY	25,714	16.9	17,682	11.6	11,511	7.5	4,895	3.2	1,276	0.8
AUGUSTA COUNTY	8,203	15.3	5,860	10.9	3,771	7.0	1,630	3.0	459	0.9
BATH COUNTY	1,059	18.1	793	13.5	491	8.4	258	4.4	44	0.8
BEDFORD COUNTY	5,640	16.1	3,990	11.4	2,599	7.4	1,102	3.2	289	0.8
BLAND COUNTY	1,038	16.3	761	12.0	479	7.5	230	3.6	52	0.8
BOTETOURT COUNTY	3,496	15.0	2,439	10.5	1,536	6.6	730	3.1	173	0.7
BRUNSWICK COUNTY	2,832	18.1	1,964	12.6	1,315	8.4	503	3.2	146	0.9
BUCHANAN COUNTY	3,763	9.9	2,566	6.8	1,730	4.6	687	1.8	149	0.4
BUCKINGHAM COUNTY	2,230	19.0	1,629	13.9	1,045	8.9	466	4.0	118	1.0
CAMPBELL COUNTY	5,727	12.6	3,954	8.7	2,555	5.6	1,105	2.4	294	0.6
CAROLINE COUNTY	2,555	14.3	1,780	9.9	1,145	6.4	517	2.9	118	0.7
CARROLL COUNTY	5,102	18.7	3,726	13.7	2,279	8.4	1,194	4.4	253	0.9
CHARLES CITY COUNTY	790	11.8	562	8.4	372	5.6	137	2.0	53	0.8
CHARLOTTE COUNTY	2,343	19.1	1,679	13.7	1,012	8.3	535	4.4	132	1.1
CHESTERFIELD COUNTY	10,324	7.3	6,514	4.6	4,366	3.1	1,680	1.2	468	0.3
CLARKE COUNTY	1,881	18.9	1,349	13.5	813	8.2	414	4.2	122	1.2
CRAIG COUNTY	719	18.2	509	12.9	311	7.9	157	4.0	41	1.0
CULPEPER COUNTY	3,930	17.4	2,891	12.8	1,715	7.6	879	3.9	297	1.3
CUMBERLAND COUNTY	1,436	18.2	1,072	13.6	654	8.3	355	4.5	63	0.8
DICKENSON COUNTY	2,698	13.6	1,860	9.4	1,205	6.1	527	2.7	128	0.6
DINWIDDIE COUNTY	3,414	15.1	2,466	10.9	1,552	6.9	724	3.2	190	0.8
ESSEX COUNTY	1,842	20.8	1,383	15.6	845	9.5	390	4.4	148	1.7
FAIRFAX COUNTY	46,040	7.7	26,989	4.5	18,082	3.0	6,808	1.1	2,099	0.4
FAUQUIER COUNTY	4,748	13.2	3,336	9.3	2,063	5.7	975	2.7	298	0.8
FLOYD COUNTY	2,421	20.9	1,803	15.6	1,102	9.5	528	4.6	173	1.5
FLUVANNA COUNTY	1,683	16.4	1,218	11.9	772	7.5	355	3.5	91	0.9
FRANKLIN COUNTY	5,442	15.2	3,883	10.9	2,428	6.8	1,149	3.2	306	0.9
FREDERICK COUNTY	4,074	11.9	2,787	8.2	1,827	5.3	744	2.2	216	0.6
GILES COUNTY	3,163	17.8	2,143	12.0	1,421	8.0	590	3.3	132	0.7
GLOUCESTER COUNTY	3,357	16.7	2,384	11.9	1,492	7.4	664	3.3	228	1.1
GOOCHLAND COUNTY	1,748	14.9	1,297	11.0	814	6.9	377	3.2	106	0.9
GRAYSON COUNTY	3,298	19.9	2,370	14.3	1,428	8.6	744	4.5	198	1.2
GREENE COUNTY	980	12.9	686	9.0	438	5.7	201	2.6	47	0.6
GREENSVILLE COUNTY	1,640	15.0	1,177	10.8	813	7.5	305	2.8	59	0.5
HALIFAX COUNTY	5,541	18.1	3,920	12.8	2,511	8.2	1,116	3.6	293	1.0
HANOVER COUNTY	6,553	13.0	4,511	9.0	2,929	5.8	1,246	2.5	336	0.7
HENRICO COUNTY	26,115	14.4	17,897	9.9	11,154	6.2	5,151	2.9	1,592	0.9
HENRY COUNTY	7,228	12.5	4,895	8.5	3,413	5.9	1,217	2.1	265	0.5
HIGHLAND COUNTY	668	22.7	464	15.8	296	10.1	135	4.6	33	1.1
ISLE OF WIGHT COUNTY	3,162	14.6	2,157	10.0	1,430	6.6	591	2.7	136	0.6
JAMES CITY COUNTY	3,180	14.0	2,129	9.4	1,348	5.9	570	2.5	211	0.9
KING AND QUEEN COUNTY	1,156	19.4	827	13.9	542	9.1	218	3.7	67	1.1

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
KING GEORGE COUNTY	1,304	12.4	875	8.3	565	5.4	244	2.3	66	0.6
KING WILLIAM COUNTY	1,498	16.0	1,070	11.5	712	7.6	281	3.0	77	0.8
LANCASTER COUNTY	2,946	29.1	2,169	21.4	1,294	12.8	674	6.7	201	2.0
LEE COUNTY	4,915	18.9	3,619	13.9	2,269	8.7	1,097	4.2	253	1.0
LOUDOUN COUNTY	5,509	9.6	3,874	6.7	2,378	4.1	1,207	2.1	289	0.5
LOUISA COUNTY	3,102	17.4	2,236	12.5	1,451	8.1	627	3.5	158	0.9
LUNENBURG COUNTY	2,407	19.9	1,671	13.8	1,032	8.5	500	4.1	139	1.1
MADISON COUNTY	1,945	19.0	1,451	14.2	870	8.5	426	4.2	155	1.5
MATHEWS COUNTY	2,313	28.9	1,756	22.0	1,033	12.9	551	6.9	172	2.2
MECKLENBURG COUNTY	5,709	19.4	4,069	13.8	2,622	8.9	1,135	3.9	312	1.1
MIDDLESEX COUNTY	2,106	27.3	1,541	20.0	930	12.0	462	6.0	149	1.9
MONTGOMERY COUNTY	6,166	9.7	4,368	6.9	2,746	4.3	1,239	2.0	383	0.6
NELSON COUNTY	2,470	20.2	1,825	15.0	1,160	9.5	514	4.2	151	1.2
NEW KENT COUNTY	1,108	12.6	761	8.7	538	6.1	171	1.9	52	0.6
NORTHAMPTON COUNTY	3,229	22.1	2,381	16.3	1,454	9.9	732	5.0	195	1.3
NORTHUMBERLAND COUNTY	2,781	28.3	1,983	20.2	1,247	12.7	593	6.0	143	1.5
NOTTOWAY COUNTY	3,347	22.8	2,458	16.8	1,442	9.8	777	5.3	239	1.6
ORANGE COUNTY	3,409	18.9	2,410	13.3	1,552	8.6	661	3.7	197	1.1
PAGE COUNTY	3,499	18.0	2,517	13.0	1,558	8.0	752	3.9	207	1.1
PATRICK COUNTY	3,274	18.6	2,339	13.3	1,392	7.9	735	4.2	212	1.2
PITTSYLVANIA COUNTY	10,232	15.5	7,138	10.8	4,661	7.0	1,974	3.0	503	0.8
POWHATAN COUNTY	1,358	10.4	878	6.7	540	4.1	266	2.0	72	0.6
PRINCE EDWARD COUNTY	2,859	17.4	2,108	12.8	1,312	8.0	605	3.7	191	1.2
PRINCE GEORGE COUNTY	1,492	5.8	947	3.7	635	2.5	242	0.9	70	0.3
PRINCE WILLIAM COUNTY	5,543	3.8	3,525	2.4	2,327	1.6	938	0.6	260	0.2
PULASKI COUNTY	5,633	16.0	3,970	11.3	2,563	7.3	1,117	3.2	290	0.8
RAPPAHANNOCK COUNTY	1,110	18.2	807	13.2	514	8.4	234	3.8	59	1.0
RICHMOND COUNTY	1,422	20.5	1,051	15.1	662	9.5	313	4.5	76	1.1
ROANOKE COUNTY	9,942	13.6	7,028	9.6	4,150	5.7	2,173	3.0	705	1.0
ROCKBRIDGE COUNTY	2,948	16.5	2,042	11.4	1,341	7.5	558	3.1	143	0.8
ROCKINGHAM COUNTY	8,311	14.6	5,887	10.3	3,552	6.2	1,769	3.1	566	1.0
RUSSELL COUNTY	4,502	14.2	3,213	10.1	2,088	6.6	916	2.9	209	0.7
SCOTT COUNTY	4,707	18.8	3,362	13.4	2,103	8.4	1,010	4.0	249	1.0
SHENANDOAH COUNTY	5,500	20.0	4,087	14.8	2,506	9.1	1,219	4.4	362	1.3
SMYTH COUNTY	5,930	17.8	4,228	12.7	2,695	8.1	1,202	3.6	331	1.0
SOUTHAMPTON COUNTY	3,017	16.1	2,040	10.9	1,337	7.1	594	3.2	109	0.6
SPOTSYLVANIA COUNTY	3,448	10.0	2,260	6.6	1,518	4.4	570	1.7	172	0.5
STAFFORD COUNTY	3,341	8.3	2,229	5.5	1,476	3.6	561	1.4	192	0.5
SURRY COUNTY	1,126	18.6	803	13.3	528	8.7	216	3.6	59	1.0
SUSSEX COUNTY	1,882	17.3	1,339	12.3	902	8.3	346	3.2	91	0.8
TAZEWELL COUNTY	7,342	14.5	5,108	10.1	3,354	6.6	1,430	2.8	324	0.6
WARREN COUNTY	3,734	17.6	2,580	12.2	1,786	8.4	641	3.0	153	0.7
WASHINGTON COUNTY	7,555	16.3	5,415	11.6	3,373	7.3	1,656	3.6	386	0.8
WESTMORELAND COUNTY	3,212	22.9	2,289	16.3	1,522	10.8	610	4.3	157	1.1
WISE COUNTY	6,421	14.6	4,555	10.4	2,886	6.6	1,335	3.0	334	0.8
WYTHE COUNTY	4,515	17.7	3,252	12.7	2,012	7.9	952	3.7	288	1.1
YORK COUNTY	2,974	8.4	1,913	5.4	1,310	3.7	487	1.4	116	0.3
ALEXANDRIA CITY	13,818	13.4	9,465	9.2	5,743	5.6	2,763	2.7	959	0.9
BEDFORD CITY	1,778	29.7	1,411	23.6	728	12.2	466	7.8	217	3.6
BRISTOL CITY	3,854	20.2	2,829	14.9	1,714	9.0	906	4.8	209	1.1
BUENA VISTA CITY	1,052	15.7	730	10.9	482	7.2	201	3.0	47	0.7
CHARLOTTESVILLE CITY	6,089	15.3	4,547	11.4	2,669	6.7	1,385	3.5	493	1.2
CHESAPEAKE CITY	12,250	10.7	8,088	7.1	5,299	4.6	2,166	1.9	623	0.5
CLIFTON FORGE CITY	1,372	27.2	1,089	21.6	556	11.0	387	7.7	146	2.9
COLONIAL HEIGHTS CITY	2,354	14.3	1,493	9.0	921	5.6	449	2.7	123	0.7
COVINGTON CITY	2,161	23.8	1,605	17.7	1,069	11.8	436	4.8	100	1.1
DANVILLE CITY	9,671	21.2	7,028	15.4	4,215	9.2	2,239	4.9	574	1.3

AREA	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
EMPORIA CITY	1,243	25.7	902	18.6	515	10.6	288	6.0	99	2.0
FAIRFAX CITY	1,795	9.3	1,080	5.6	668	3.4	275	1.4	137	0.7
FALLS CHURCH CITY	1,872	19.7	1,316	13.8	880	9.2	356	3.7	80	0.8
FRANKLIN CITY	1,345	18.4	936	12.8	621	8.5	236	3.2	79	1.1
FREDERICKSBURG CITY	3,002	19.6	2,245	14.7	1,384	9.0	714	4.7	147	1.0
GALAX CITY	1,511	23.2	1,159	17.8	690	10.6	361	5.5	108	1.7
HAMPTON CITY	13,254	10.8	8,525	7.0	5,606	4.6	2,276	1.9	643	0.5
HARRISONBURG CITY	2,821	14.3	2,124	10.8	1,205	6.1	679	3.5	240	1.2
HOPEWELL CITY	3,585	15.3	2,554	10.9	1,629	7.0	705	3.0	220	0.9
LEXINGTON CITY	1,173	16.1	894	12.3	513	7.0	299	4.1	82	1.1
LYNCHBURG CITY	12,490	18.7	9,324	14.0	5,482	8.2	2,935	4.4	907	1.4
MANASSAS CITY	1,216	7.9	911	5.9	501	3.2	290	1.9	120	0.8
MANASSAS PARK CITY	275	4.2	165	2.5	118	1.8	37	0.6	10	0.2
MARTINSVILLE CITY	3,889	21.4	2,819	15.5	1,803	9.9	753	4.1	263	1.4
NEWPORT NEWS CITY	17,100	11.8	11,372	7.8	7,298	5.0	3,082	2.1	992	0.7
NORFOLK CITY	35,159	13.2	24,475	9.2	15,409	5.8	7,255	2.7	1,811	0.7
NORTON CITY	833	17.5	604	12.7	365	7.7	172	3.6	67	1.4
PETERSBURG CITY	6,906	16.8	4,746	11.6	2,988	7.3	1,358	3.3	400	1.0
POQUOSON CITY	875	10.0	592	6.8	394	4.5	167	1.9	31	0.4
PORTSMOUTH CITY	16,632	15.9	11,242	10.7	7,193	6.9	3,226	3.1	823	0.8
RADFORD CITY	1,741	13.2	1,206	9.1	757	5.7	365	2.8	84	0.6
RICHMOND CITY	41,909	19.1	30,838	14.1	18,604	8.5	9,494	4.3	2,740	1.2
ROANOKE CITY	21,039	21.0	15,678	15.6	8,984	9.0	5,251	5.2	1,443	1.4
SALEM CITY	4,301	18.0	3,114	13.0	1,842	7.7	954	4.0	318	1.3
SOUTH BOSTON CITY	1,533	21.6	1,121	15.8	656	9.2	348	4.9	117	1.6
STAUNTON CITY	4,485	20.5	3,290	15.1	1,992	9.1	972	4.4	326	1.5
SUFFOLK CITY	7,906	16.6	5,467	11.5	3,541	7.4	1,503	3.2	423	0.9
VIRGINIA BEACH CITY	18,542	7.1	11,913	4.5	7,683	2.9	3,260	1.2	970	0.4
WAYNESBORO CITY	2,814	18.4	1,906	12.4	1,286	8.4	490	3.2	130	0.8
WILLIAMSBURG CITY	1,339	13.6	1,025	10.4	608	6.2	320	3.2	97	1.0
WINCHESTER CITY	4,148	20.5	3,053	15.1	1,791	8.9	978	4.8	284	1.4
WASHINGTON	610,599	14.8	431,562	10.4	263,347	6.4	126,739	3.1	41,476	1.0
ADAMS COUNTY	1,715	12.9	1,154	8.7	688	5.2	350	2.6	116	0.9
ASOTIN COUNTY	3,226	19.2	2,398	14.3	1,400	8.3	752	4.5	246	1.5
BENTON COUNTY	11,084	10.1	7,219	6.6	4,908	4.5	1,798	1.6	513	0.5
CHELAN COUNTY	9,259	20.5	6,828	15.2	3,978	8.8	2,182	4.8	668	1.5
CLALLAM COUNTY	10,277	19.9	7,312	14.2	4,687	9.1	2,067	4.0	558	1.1
CLARK COUNTY	24,874	12.9	17,379	9.0	10,979	5.7	4,895	2.5	1,505	0.8
COLUMBIA COUNTY	998	24.6	727	17.9	414	10.2	238	5.9	75	1.8
COWLITZ COUNTY	12,060	15.2	8,611	10.8	5,393	6.8	2,436	3.1	782	1.0
DOUGLAS COUNTY	3,245	14.7	2,265	10.2	1,489	6.7	623	2.8	153	0.7
FERRY COUNTY	715	12.3	490	8.4	331	5.7	118	2.0	41	0.7
FRANKLIN COUNTY	4,093	11.7	2,661	7.6	1,722	4.9	713	2.0	226	0.6
GARFIELD COUNTY	587	23.8	415	16.8	235	9.5	127	5.1	53	2.1
GRANT COUNTY	7,138	14.7	4,754	9.8	3,174	6.5	1,250	2.6	330	0.7
GRAYS HARBOR COUNTY	11,760	17.7	8,396	12.7	5,300	8.0	2,371	3.6	725	1.1
ISLAND COUNTY	7,095	16.1	4,821	10.9	3,364	7.6	1,147	2.6	310	0.7
JEFFERSON COUNTY	3,602	22.6	2,518	15.8	1,732	10.8	596	3.7	190	1.2
KING COUNTY	184,340	14.5	129,414	10.2	77,047	6.1	38,863	3.1	13,504	1.1
KITSAP COUNTY	20,653	14.0	14,529	9.9	8,998	6.1	4,216	2.9	1,315	0.9
KITTITAS COUNTY	4,054	16.3	2,942	11.8	1,804	7.3	819	3.3	319	1.3
KLICKITAT COUNTY	2,786	17.6	1,943	12.3	1,228	7.8	549	3.5	166	1.0
LEWIS COUNTY	10,413	18.6	7,623	13.6	4,565	8.1	2,294	4.1	764	1.4
LINCOLN COUNTY	2,202	22.9	1,615	16.3	935	9.7	504	5.2	176	1.8
MASON COUNTY	5,901	18.9	3,934	12.6	2,597	8.3	1,082	3.5	255	0.8
OKANOGAN COUNTY	5,312	17.3	3,870	12.6	2,369	7.7	1,142	3.7	359	1.2
PACIFIC COUNTY	4,166	24.2	2,968	17.2	1,941	11.3	785	4.6	242	1.4

AREA NAME	POPULATION 60+ #	POPULATION 60+ %	POPULATION 65+ #	POPULATION 65+ %	POP 65-74 #	POP 65-74 %	POP 75-84 #	POP 75-84 %	POP 85+ #	POP 85+ %
PEND OREILLE COUNTY	1,501	17.5	1,034	12.1	665	7.8	279	3.3	90	1.0
PIERCE COUNTY	64,931	13.4	45,530	9.4	27,599	5.7	13,780	2.8	4,151	0.9
SAN JUAN COUNTY	1,972	25.2	1,341	17.1	927	11.8	322	4.1	92	1.2
SKAGIT COUNTY	12,183	19.0	8,782	13.7	5,448	8.5	2,561	4.0	773	1.2
SKAMANIA COUNTY	1,096	13.8	759	9.6	530	6.7	182	2.3	47	0.6
SNOHOMISH COUNTY	42,335	12.5	29,532	8.7	18,457	5.5	8,332	2.5	2,743	0.8
SPOKANE COUNTY	54,436	15.9	39,453	11.5	23,345	6.8	11,887	3.5	4,221	1.2
STEVENS COUNTY	4,149	14.3	2,966	10.2	1,841	6.4	849	2.9	276	1.0
THURSTON COUNTY	17,336	14.0	12,230	9.8	7,406	6.0	3,703	3.0	1,121	0.9
WAHKIAKUM COUNTY	753	19.7	534	13.9	331	8.6	147	3.8	56	1.5
WALLA WALLA COUNTY	8,700	18.3	6,446	13.6	3,611	7.6	2,056	4.3	779	1.6
WHATCOM COUNTY	16,281	15.3	11,967	11.2	7,049	6.6	3,637	3.4	1,281	1.2
WHITMAN COUNTY	4,452	11.1	3,281	8.2	1,938	4.8	1,000	2.5	343	0.9
YAKIMA COUNTY	28,919	16.8	20,921	12.1	12,922	7.5	6,087	3.5	1,912	1.1
WEST VIRGINIA	330,525	17.0	237,868	12.2	147,298	7.6	71,161	3.6	19,409	1.0
BARBOUR COUNTY	3,160	19.0	2,352	14.1	1,404	8.4	715	4.3	233	1.4
BERKELEY COUNTY	7,577	16.2	5,325	11.4	3,418	7.3	1,525	3.3	382	0.8
BOONE COUNTY	4,148	13.6	2,919	9.6	1,866	6.1	841	2.8	212	0.7
BRAXTON COUNTY	2,902	20.9	2,184	15.7	1,320	9.5	692	5.0	172	1.2
BROOKE COUNTY	5,038	16.2	3,510	11.3	2,219	7.1	1,034	3.3	257	0.8
CABELL COUNTY	19,830	18.6	14,601	13.7	8,643	8.1	4,705	4.4	1,253	1.2
CALHOUN COUNTY	1,662	20.1	1,256	15.2	789	9.6	390	4.7	77	0.9
CLAY COUNTY	1,803	16.0	1,329	11.8	841	7.5	390	3.5	98	0.9
DODDRIDGE COUNTY	1,505	20.2	1,146	15.4	677	9.1	364	4.9	105	1.4
FAYETTE COUNTY	10,784	18.6	7,870	13.6	5,005	8.6	2,302	4.0	563	1.0
GILMER COUNTY	1,548	18.6	1,223	14.7	739	8.9	371	4.5	113	1.4
GRANT COUNTY	1,722	16.9	1,226	12.0	765	7.5	372	3.6	89	0.9
GREENBRIER COUNTY	7,279	19.3	5,475	14.5	3,369	8.9	1,629	4.3	477	1.3
HAMPSHIRE COUNTY	2,556	17.2	1,841	12.4	1,182	8.0	518	3.5	141	0.9
HANCOCK COUNTY	6,642	16.4	4,524	11.2	2,954	7.3	1,207	3.0	363	0.9
HARDY COUNTY	1,914	19.1	1,387	13.8	862	8.6	415	4.1	110	1.1
HARRISON COUNTY	15,574	20.0	11,306	14.5	6,953	8.9	3,343	4.3	1,010	1.3
JACKSON COUNTY	3,680	14.3	2,653	10.3	1,576	6.1	836	3.2	241	0.9
JEFFERSON COUNTY	4,483	14.8	3,070	10.1	2,018	6.7	800	2.6	252	0.8
KANAWHA COUNTY	39,455	17.0	27,593	11.9	17,458	7.5	8,027	3.5	2,108	0.9
LEWIS COUNTY	4,035	21.4	3,060	16.3	1,785	9.5	1,004	5.3	271	1.4
LINCOLN COUNTY	3,513	14.8	2,535	10.7	1,615	6.8	724	3.1	196	0.8
LOGAN COUNTY	6,884	13.6	4,769	9.4	3,162	6.2	1,343	2.7	264	0.5
MCDOWELL COUNTY	7,430	14.9	5,151	10.3	3,460	6.9	1,383	2.8	308	0.6
MARION COUNTY	12,975	19.7	9,406	14.3	5,668	8.6	2,929	4.5	809	1.2
MARSHALL COUNTY	6,920	16.6	4,880	11.7	3,041	7.3	1,435	3.4	404	1.0
MASON COUNTY	4,263	15.8	3,150	11.6	1,934	7.2	937	3.5	279	1.0
MERCER COUNTY	13,355	18.1	9,556	12.9	5,937	8.0	2,876	3.9	743	1.0
MINERAL COUNTY	4,567	16.8	3,224	11.8	2,044	7.5	927	3.4	253	0.9
MINGO COUNTY	4,636	12.4	3,171	8.5	1,984	5.3	951	2.5	236	0.6
MONONGALIA COUNTY	9,656	12.9	6,925	9.2	4,091	5.5	2,182	2.9	652	0.9
MONROE COUNTY	2,563	19.9	1,873	14.5	1,116	8.7	591	4.6	166	1.3
MORGAN COUNTY	1,966	18.4	1,431	13.4	884	8.3	436	4.1	111	1.0
NICHOLAS COUNTY	4,184	14.9	2,966	10.5	1,865	6.6	901	3.2	200	0.7
OHIO COUNTY	12,888	21.0	9,420	15.3	5,578	9.1	3,004	4.9	838	1.4
PENDLETON COUNTY	1,628	20.6	1,214	15.3	728	9.2	279	4.8	107	1.4
PLEASANTS COUNTY	1,277	15.5	916	11.1	568	6.9	278	3.4	70	0.8
POCAHONTAS COUNTY	2,157	21.7	1,622	16.4	1,014	10.2	461	4.6	147	1.5
PRESTON COUNTY	5,203	17.1	3,857	12.7	2,268	7.4	1,199	3.9	390	1.3
PUTNAM COUNTY	4,871	12.8	3,402	8.9	2,225	5.8	944	2.5	233	0.6
RALEIGH COUNTY	14,522	16.7	10,389	12.0	6,518	7.5	3,033	3.5	838	1.0
RANDOLPH COUNTY	5,256	18.3	3,874	13.5	2,414	8.4	1,105	3.8	355	1.2

AREA NAME	POPULATION 60+ #	%	POPULATION 65+ #	%	POP 65-74 #	%	POP 75-84 #	%	POP 85+ #	%
RITCHIE COUNTY	2,541	22.2	1,917	16.8	1,080	9.4	629	5.5	208	1.8
ROANE COUNTY	3,098	19.4	2,267	14.2	1,375	8.6	712	4.5	180	1.1
SUMMERS COUNTY	2,969	18.7	2,162	13.6	1,346	8.5	669	4.2	147	0.9
TAYLOR COUNTY	3,088	18.6	2,351	14.2	1,353	8.2	767	4.6	231	1.4
TUCKER COUNTY	1,812	20.9	1,368	15.8	831	9.6	407	4.7	130	1.5
TYLER COUNTY	1,984	17.5	1,487	13.1	920	8.1	454	4.0	113	1.0
UPSHUR COUNTY	3,943	16.8	2,933	12.5	1,701	7.3	918	3.9	314	1.3
WAYNE COUNTY	6,853	14.9	4,827	10.5	3,063	6.7	1,420	3.1	344	0.7
WEBSTER COUNTY	2,146	17.5	1,592	13.0	1,028	8.4	458	3.7	106	0.9
WETZEL COUNTY	3,648	16.7	2,701	12.3	1,600	7.3	866	4.0	235	1.1
WIRT COUNTY	905	18.4	657	13.3	425	8.6	192	3.9	40	0.8
WOOD COUNTY	15,575	16.6	11,364	12.1	6,812	7.3	3,482	3.7	1,070	1.1
WYOMING COUNTY	3,952	11.0	2,661	7.4	1,807	5.0	689	1.9	165	0.5
WISCONSIN	771,144	16.4	584,197	12.0	350,415	7.0	178,145	3.8	55,637	1.2
ADAMS COUNTY	3,207	23.8	2,306	17.1	1,488	11.1	617	4.6	201	1.5
ASHLAND COUNTY	3,795	22.6	2,888	17.2	1,657	9.9	925	5.5	306	1.8
BARRON COUNTY	8,138	21.0	6,083	15.7	3,482	9.0	1,980	5.1	621	1.6
BAYFIELD COUNTY	3,182	23.0	2,373	17.2	1,594	11.5	654	4.7	125	0.9
BROWN COUNTY	23,095	13.2	16,823	9.6	10,092	5.8	5,223	3.0	1,508	0.9
BUFFALO COUNTY	2,979	20.8	2,293	16.0	1,255	8.8	776	5.4	262	1.8
BURNETT COUNTY	3,126	25.3	2,282	18.5	1,441	11.7	662	5.4	179	1.5
CALUMET COUNTY	4,226	13.7	2,987	9.7	1,806	5.9	894	2.9	287	0.9
CHIPPEWA COUNTY	8,970	17.2	6,622	12.7	3,831	7.3	2,101	4.0	690	1.3
CLARK COUNTY	6,724	20.4	5,124	15.6	2,947	9.0	1,610	4.9	567	1.7
COLUMBIA COUNTY	8,465	19.6	6,319	14.6	3,506	8.1	2,042	4.7	771	1.8
CRAWFORD COUNTY	3,349	20.2	2,518	15.2	1,417	8.6	853	5.2	248	1.5
DANE COUNTY	37,630	11.6	27,036	8.4	15,431	4.8	8,599	2.7	3,006	0.9
DODGE COUNTY	13,427	17.9	9,960	13.3	5,663	7.5	3,202	4.3	1,095	1.5
DOOR COUNTY	5,483	21.9	4,003	16.0	2,498	10.0	1,189	4.8	316	1.3
DOUGLAS COUNTY	8,602	19.4	6,358	14.3	3,816	8.6	1,949	4.4	593	1.3
DUNN COUNTY	5,343	15.6	4,071	11.9	2,271	6.6	1,394	4.1	406	1.2
EAU CLAIRE COUNTY	11,863	15.1	8,658	11.0	4,979	6.3	2,800	3.6	879	1.1
FLORENCE COUNTY	969	23.2	727	17.4	440	10.5	219	5.2	68	1.6
FOND DU LAC COUNTY	14,864	16.7	11,031	12.4	6,200	7.0	3,614	4.1	1,217	1.4
FOREST COUNTY	1,956	21.6	1,478	16.3	971	10.7	366	4.0	141	1.6
GRANT COUNTY	8,832	17.1	6,732	13.0	3,646	7.0	2,286	4.4	800	1.5
GREEN COUNTY	5,580	18.6	4,184	13.9	2,324	7.7	1,368	4.6	492	1.6
GREEN LAKE COUNTY	4,309	23.5	3,263	17.8	1,944	10.6	987	5.4	332	1.8
IOWA COUNTY	3,523	17.8	2,613	13.2	1,487	7.5	876	4.4	250	1.3
IRON COUNTY	1,876	27.9	1,386	20.6	876	13.0	401	6.0	109	1.6
JACKSON COUNTY	3,606	21.4	2,705	16.1	1,613	9.6	802	4.8	290	1.7
JEFFERSON COUNTY	11,107	16.8	8,189	12.4	4,823	7.3	2,591	3.9	775	1.2
JUNEAU COUNTY	4,551	21.6	3,334	15.8	2,046	9.7	1,012	4.8	276	1.3
KENOSHA COUNTY	18,751	15.2	13,284	10.8	7,976	6.5	4,057	3.3	1,251	1.0
KEWAUNEE COUNTY	3,680	18.8	2,708	13.9	1,637	8.4	804	4.1	267	1.4
LA CROSSE COUNTY	14,739	16.2	11,001	12.1	6,246	6.9	3,608	4.0	1,147	1.3
LAFAYETTE COUNTY	3,165	18.2	2,344	13.5	1,374	7.9	713	4.1	257	1.5
LANGLADE COUNTY	4,399	22.0	3,264	16.3	1,986	9.9	966	4.8	312	1.6
LINCOLN COUNTY	5,326	20.1	4,032	15.2	2,359	8.9	1,282	4.8	391	1.5
MANITOWOC COUNTY	15,240	18.4	11,271	13.6	6,489	7.8	3,722	4.5	1,060	1.3
MARATHON COUNTY	16,723	15.0	12,050	10.8	7,258	6.5	3,607	3.2	1,185	1.1
MARINETTE COUNTY	8,556	21.8	6,343	16.1	3,850	9.8	1,942	4.9	551	1.4
MARQUETTE COUNTY	2,949	25.3	2,162	18.5	1,369	11.7	628	5.4	165	1.4
MENOMINEE COUNTY	347	10.3	237	7.0	175	5.2	55	1.6	7	0.2
MILWAUKEE COUNTY	166,823	17.3	121,547	12.6	71,272	7.4	39,197	4.1	11,078	1.1
MONROE COUNTY	6,618	18.9	4,821	13.7	2,668	7.6	1,604	4.6	549	1.6
OCONTO COUNTY	5,946	20.5	4,334	15.0	2,689	9.3	1,283	4.4	362	1.3

AREA NAME	POPULATION 60+		POPULATION 65+		POP 65-74		POP 75-84		POP 85+	
	#	%	#	%	#	%	#	%	#	%
ONEIDA COUNTY	6,542	21.0	4,707	15.1	3,097	9.9	1,263	4.0	347	1.1
OUTAGAMIE COUNTY	17,580	13.6	12,792	9.9	7,585	5.9	4,033	3.1	1,174	0.9
OZAUKEE COUNTY	8,251	12.3	5,662	8.5	3,473	5.2	1,727	2.6	462	0.7
PEPIN COUNTY	1,611	21.5	1,272	17.0	690	9.2	433	5.8	149	2.0
PiERCE COUNTY	4,345	13.9	3,210	10.3	1,820	5.8	1,040	3.3	350	1.1
POLK COUNTY	6,634	20.5	5,039	15.6	2,906	9.0	1,641	5.1	492	1.5
PORTAGE COUNTY	7,758	13.5	5,731	10.0	3,391	5.9	1,806	3.1	534	0.9
PRICE COUNTY	3,671	23.3	2,777	17.6	1,694	10.7	832	5.3	251	1.6
RACINE COUNTY	24,603	14.2	17,580	10.2	10,168	5.9	5,560	3.2	1,852	1.1
RICHLAND COUNTY	3,727	21.3	2,758	15.8	1,588	9.1	876	5.0	294	1.7
ROCK COUNTY	20,739	14.9	15,293	11.0	8,897	6.4	4,796	3.4	1,600	1.1
RUSK COUNTY	3,264	20.9	2,363	15.2	1,418	9.1	699	4.5	246	1.6
ST. CROIX COUNTY	5,861	13.5	4,434	10.2	2,313	5.3	1,500	3.5	621	1.4
SAUK COUNTY	8,784	20.2	6,607	15.2	3,756	8.6	2,076	4.8	775	1.8
SAWYER COUNTY	3,095	24.1	2,232	17.4	1,473	11.5	615	4.8	144	1.1
SHAWANO COUNTY	7,769	21.6	5,710	15.9	3,384	9.4	1,745	4.9	581	1.6
SHEBOYGAN COUNTY	18,235	18.1	13,436	13.3	7,845	7.8	4,306	4.3	1,285	1.3
TAYLOR COUNTY	3,484	18.5	2,597	13.8	1,547	8.2	780	4.1	270	1.4
TREMPEALEAU COUNTY	5,631	21.5	4,277	16.1	2,324	8.8	1,452	5.6	501	1.9
VERNON COUNTY	5,857	22.8	4,423	17.2	2,472	9.6	1,471	5.7	480	1.9
VILAS COUNTY	4,460	27.0	3,231	19.5	2,164	13.1	872	5.3	195	1.2
WALWORTH COUNTY	12,346	17.3	9,182	12.8	5,424	7.6	2,836	4.0	922	1.3
WASHBURN COUNTY	3,080	23.4	2,226	16.9	1,363	10.3	689	5.2	174	1.3
WASHINGTON COUNTY	10,023	11.8	7,125	8.4	4,106	4.8	2,189	2.6	830	1.0
WAUKESHA COUNTY	30,698	11.0	20,914	7.5	12,528	4.5	6,303	2.2	2,083	0.7
WAUPACA COUNTY	9,740	22.7	7,449	17.4	3,993	9.3	2,507	5.9	949	2.2
WAUSHARA COUNTY	4,438	24.0	3,378	18.2	2,088	11.3	1,009	5.4	281	1.5
WINNEBAGO COUNTY	21,025	16.0	15,288	11.6	8,958	6.8	4,819	3.7	1,511	1.1
WOOD COUNTY	11,854	16.3	8,760	12.0	5,058	6.9	2,810	3.9	892	1.2
WYOMING	52,779	11.2	37,175	7.9	22,867	4.9	10,835	2.3	3,473	0.7
ALBANY COUNTY	2,827	9.7	2,005	6.9	1,220	4.2	599	2.1	186	0.6
BIG HORN COUNTY	2,219	18.7	1,652	13.9	1,006	8.5	497	4.2	149	1.3
CAMPBELL COUNTY	1,070	4.4	693	2.8	426	1.7	184	0.8	83	0.3
CARBON COUNTY	2,152	9.8	1,513	6.9	929	4.2	443	2.0	141	0.6
CONVERSE COUNTY	1,089	7.7	780	5.5	453	3.2	229	1.6	98	0.7
CROOK COUNTY	790	14.1	501	9.4	342	6.4	130	2.4	29	0.5
FREMONT COUNTY	3,905	10.0	2,728	7.0	1,787	4.6	730	1.9	211	0.5
GOSHEN COUNTY	2,365	19.6	1,771	14.7	1,041	8.6	544	4.5	186	1.5
HOT SPRINGS COUNTY	1,208	21.2	930	16.3	500	8.8	303	5.3	127	2.2
JOHNSON COUNTY	1,222	18.2	927	13.8	517	7.7	302	4.5	108	1.6
LARAMIE COUNTY	8,557	12.5	6,023	8.8	3,649	5.3	1,841	2.7	533	0.8
LINCOLN COUNTY	1,473	12.1	1,003	8.2	666	5.5	255	2.1	82	0.7
NATRONA COUNTY	6,761	9.4	4,546	6.3	2,817	3.9	1,349	1.8	380	0.5
NIOBRARA COUNTY	663	22.7	506	17.3	299	10.2	149	5.1	58	2.0
PARK COUNTY	3,135	14.5	2,244	10.4	1,442	6.7	594	2.7	208	1.0
PLATTE COUNTY	1,503	12.6	1,062	9.0	671	5.6	305	2.5	106	0.9
SHERIDAN COUNTY	4,126	16.5	2,984	11.9	1,759	7.0	890	3.6	335	1.3
SUBLETTE COUNTY	558	12.3	379	8.3	262	5.8	92	2.0	25	0.5
SWEETWATER COUNTY	3,108	7.4	2,068	5.0	1,282	3.1	616	1.5	170	0.4
TETON COUNTY	721	7.7	486	5.2	330	3.5	130	1.4	26	0.3
UINTA COUNTY	1,138	8.7	775	6.0	483	3.7	226	1.7	66	0.5
WASHAKIE COUNTY	1,299	13.7	922	9.7	592	6.2	245	2.6	85	0.9
WESTON COUNTY	930	13.1	657	9.2	394	5.5	182	2.6	81	1.1